THE MEANINGS OF FRAILTY AND AGING-IN-PLACE FOR FLORIDA'S HUD MANAGERS AND THEIR ELDERLY TENANTS

By

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by

Michael Phillips Wilson

For my wife, Jody,
My past, present and future.

To the past,
Helen Miller Greenawalt, Nancy F. Wilson, Samuel P. Wilson, and Lillian Wilson

To the present,
Robert P. Wilson, Elizabeth A. Wilson, Cheryl L. Ellis, and Clare E. Greenawalt.

To the future,
Ashley Kathryn Ellis.

Here's to a Booming Future.

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Long-term care services for elders, like nursing homes and board and care facilities, represent a substantial share of total health care spending in the United States. This study attempts to understand the "triggering mechanisms" that low-income housing managers use to determine elders' abilities to remain in housing projects. By understanding how Florida's HUD managers and their elder tenants ascribe meanings to frailty and aging-in-place, more supportive housing environments can be created and premature institutionalization can be minimized.

Interviews were conducted with 48 housing managers and 105 residents based on a transactionalist perspective of environmental congruence. From these interviews, personal constructions of aging-in-place and frailty were revealed. The study participants were questioned about supportive service access, use, and residential dynamics of the housing project.

Findings suggest that the conceptualizations of frailty and aging-in-place by both managers and residents are closely linked with the facility type. The housing type determines the level of supportive services, service access, and physical design options available to maintain elders in their homes.

The residents demonstrated four models of conceptualizing frailty--medical, service, individual, and manager. Though few residents defined their frailty within any single model, many had clear enough conceptualizations to make them easily categorized.

Additionally, managers revealed three approaches to conceptualizing aging-in-place--inactive, reactive, and proactive. Each of these models describes a level of attention to resident's needs for supportive services.

Lastly, one of the most significant influences on the ability of rent-subsidized housing to maintain residents is its capacity to create networks of community-based services taking advantage of economies of scope and scale. These services are the lifeblood to maintaining frail elders in their homes. Four major models were uncovered--service inactivity, community-based service activity, on-site activity, and on-site and community-based service activity.

The importance of these findings is not simply for fiscal reasons. People must realize that bringing services to low-income seniors allows them to age-in-place with dignity and autonomy, giving them a home until *they* choose to move.

CHAPTER 1
INTRODUCTION

We want to live out our days in our apartment. I hope they'll let us.
Resident 33 to Resident 32
Central Florida

Overview

According to the United States Census Bureau (2000), America's population of age 65 or older persons grew by 74% between the period of 1970 and 1999. This overall increase from 20 to almost 35 million people will pale in comparison to the burgeoning population of the upcoming Baby-Boomers. In 1945--around the end of World War II--the United States laid the potential foundations for great economic success or dismal failure. In the stable, two-parent era of suburbia began the Baby Boom that will have a monumental impact on the United States as those children move through the lifecourse. From 1946 to 1964--the entire period now called the Baby Boom--a total of 77 million babies were born. Within the ranks of this group, America will face its greatest challenges to address the needs of an aging population as this group approaches and moves beyond their mid-sixties.

Since the mid-1850s, life expectancy has consistently increased over the last 150 years. Many researchers believe the Baby Boomers will have an average life expectancy of 78 years for males and 83 years for females. This factor, combined with other age-related challenges, will force the United States government to face some major demands when coping with this group of the population. According to historians and

demographers, recent U. S. history contains three separate and unprecedented demographic phenomena that are converging to produce what Dychtwald & Flower (1989) calls the *age wave*. These are:

1. **The Senior Boom**. Americans are living longer than ever before, and older Americans are healthier, more active, more vigorous, and more influential than any other older generation in history.
2. **The Birth Dearth**. A decade ago, fertility in the United States plummeted to its lowest point ever. It has been hovering there ever since, and it's not likely to change. The great population of elders is not being offset by an explosion of children being born.
3. **The Aging of the Baby Boom**. The leading edge of the boomer generation has passed forty. As the boomers approach fifty, and pass it, their numbers will combine with the two other great demographic changes to produce a historic shift in the concerns, structure, and style of America. (Dychtwald & Flower 1989, p. 4)

The combined effect of the first two demographic phenomena has a direct influence on the third--the aging of the Baby Boomers. The aging of this group creates an America that is increasingly concerned with the needs and desires of its middle-aged and older citizens (Thurow 1996, Dychtwald & Flower 1989).

The concerns for an aging population are great--dealing with the sheer numbers of aging Boomers and the current aging population is enough to create financial and emotional strains at the personal, local, state, and national levels. In a country like the United States that has achieved only moderate success in dealing with the spectrum of its aging population, failure to address the needs of members of this group could prove catastrophic. Unquestionably, one of the most needy sub-groups of this population will be those not making enough money to satisfy their daily needs. These elders will face a variety of obstacles in their later years, including fragmented access to services,

continued occupancy of their home, and generally limited opportunities to successful long-term care.

Long-term care services for elders, like home-based care, nursing homes, and board and care facilities, represent a substantial share of total health care spending in the United States. For this reason alone, many policy makers have made long-term care an important issue on state agendas. Nursing home and home health care accounted for 12% of personal health expenditures in 1995, and 14% of all state local health care spending (Weiner & Stevenson 1998, see also Polivka et al. 1996). In the state of Florida the potential need for long-term care is enormous. With the largest proportion of elder population in the country, Florida has great pressure from many sides to develop a low cost system of long-term care. In 1996, 19% of Florida's estimated 2.7 million people were over age 65 (Weiner & Stevenson 1998). Dunlop et al. (1996) and Lipson et al. (1997) both document the need and cost projections for long-term care of this population. Based on current and expected future disability rates and service costs, projections of need and cost through 2010 were made. Over the next ten years Florida--and the nation--will be faced with extreme demands from certain segments of the senior population for long-term care and housing that can accommodate frail seniors.

Currently, however, a gap exists between the needs of frail seniors and the services available. In terms of the compatibility between services and needs, the state creates a burdensome eligibility and service structure to obtain long-term care assistance. These systems do not exist in sufficient quantities to meet either present or future needs of Florida's elder citizenry. With respect to housing alternatives few types of affordable options at any income level are available for Florida's elders who do not need or want to

occupy a nursing home (Dunlop et al. 1996). Florida's low-income elders must confront a variety of obstacles--reduced quality of life, extreme cost expenditures for needed services, loss of autonomy and control in premature institutionalization.

This group faces tremendous disadvantages because they will not have the financial assets to address their long-term and supportive service needs as they age. Some researchers' suggestion that low-income elders face problems similar to those of other groups of poor in the country is an oversimplification. For this group there is not one but multiple complicating events and obstacles that permeate their lives. These events affect older persons differently depending on their finances, physical and mental capabilities, and lifestyle.

Older Poor People and Poverty

The condition of poverty is complex and should not be conceived of as a single problem with a single solution. Instead, race, gender, familial status, age, and place of residence all come together to influence the risk of living in poverty. For the elderly, these risks become even more influential in predicting poverty and the duration of an at-risk life event.

These diverse factors of complicating circumstances have converged to put some of the elderly at risk for poverty in old age. Currently 10% of the nation's elderly--roughly 3 million people--have annual incomes below the official government-defined poverty line. The income at the official U. S. annual poverty line for 1997 is $8,183 for a person living alone and $10,473 for a family of two adults (Everding 1999, p. 1).

Also, less education and increasing age have been shown to contribute to the risk of being poor or near poor and having catastrophic health problems. Health and poverty

have an inter-related effect: "At the time that low-income elders are experiencing greater declines in their health they also have fewer financial resources with which to cope with this poorer health" (Coward 1997, p. 1). Currently poor elders likely had low incomes throughout most of their adult lives, contributing to a lifetime of debilitating consequences that culminates in few resources, poor housing, significant health problems, and dependence in old age.

Rank & Hirschl (1999) cite a major public policy success over the last forty years for the reduction of poverty within the elderly population, mirroring the successes seen in other population sub-groups. They highlight the following:

> In 1959 the poverty rate for those aged 65 and over stood at 35.2%, representing the age group with the highest level of impoverishment. By 1997 the poverty rate for elderly adults had fallen to 10.5%. This was lower than the 13.3% rate for the overall population, and substantially lower than the 19.9% rate for the children under age of 18. (Rank & Hirschl 1999, p. S184)

While researchers cite many causes for this reduction, including Social Security increases and the Medicare program, Rank & Hirschl (1999) and other studies at state (Golant 1999, Nachison 1985) and local levels find that the likelihood of experiencing poverty varies dramatically by race, education, and marital status. In a variety of contexts, being black, having less than 12 years of education, and not being married increase the likelihood of poverty during the elderly years (Rank & Hirschl 1999, Golant 1999). Additionally, Rank & Hirschl (1999) state the following:

> In combination, these variables radically reduce or increase the cumulative chances of experiencing poverty. For example, 88.1% of not married black females with less than 12 years of education fell below the poverty line at some point during the ages of 60 to 85, whereas only 13% of married white females with 12 or more years of education were touched by poverty. (p. S191)

Implications of these findings suggest that despite the decrease in the percentage of elders in poverty, it would be a mistake to consider this issue inconsequential. The assumption

that programs like Social Security and Medicare have "solved" these problems is also incorrect.

Elders in Government-Subsidized Housing in the United States and Florida

Nationally, a small though significant portion of this subgroup of poor elders resides in government subsidized rental housing. However, most facilities were built and designed for relatively healthy elderly tenants. These buildings satisfy this group's need for housing, but few offer the types of supportive services and design features necessary to prevent premature institutionalization and to ensure aging-in-place. Additionally, few facilities have the staff needed to handle the needs of an aging, low-income population.

This type of housing addresses the most serious accommodation problems among elders' low-income accommodations. By 1997, 1.6 million elders lived in federally subsidized housing (HUD 1999). These programs have proven overwhelmingly beneficial to this subgroup, despite unfavorable opinions about entering a government housing project, and have drawn disproportionate numbers of elders into government subsidized housing.

Compared with other low-income populations, elders are disproportionately more likely to occupy government rental subsidized housing. According to Golant (1992) and Redfoot & Gaberlavage (1991), there are three key reasons that older people have received more than their share of subsidized housing units: "(1) older renters are poorer than other renters, (2) long-time residents have aged-in-place, and (3) several federal housing programs have targeted assistance to older people" (p. 117). Ultimately, however, the greatest inducement for moving into government-subsidized housing is the need for financial relief (Golant 1992, p. 147). Beyond the immediate need for housing,

these residential environments have proven to offer elders incentives for relocating; and once moved into these accommodations, they will tend to remain unless they experience physical or mental impairments that limit their ability to live independently (Golant 1992, p. 118).

Low-income elders in the state of Florida have sought housing alternatives that minimize monthly expenses and, that maximize avenues for accessible supportive services and locales to remain at home. According to Golant's CASERA Project (1999), senior households were concentrated in two federal housing programs conventional public housing (14,981) and Section 202 (14,504) accounting for roughly 21% of the subsidized elder population in rental housing. Section 8 Certificates and Vouchers used by elders (12,754) and administrated by Public Housing Agencies constitute about 13% of the elder housing population. The next largest programs are Section 236 projects (9,240) with 13%, other HUD programs comprise about 7%, Section 8 projects (3,566) with 5%, and rural housing (4,822) with 7%. This research, however, focuses on the four key low-income housing programs in the state--Section 202, Section 221, Section 236, and Section 8. Together, these four categories of housing total about 50% of Florida's low-income, elder population. In all, about 80,000 elders live in Florida's government subsidized housing (Golant 1999).

While many of the elders living in these housing facilities lead independent and active lives, a portion of them need some form of assistance with daily activities, including bathing, dressing, toileting, housekeeping, and shopping. On the horizon, an even greater proportion will require supportive services as the Baby Boomers age. For these groups of low-income, service-needy elders, government subsidized housing

becomes an obstacle or an opportunity depending upon the type of responses of housing managers and sponsors to address the needs of elders when they become frail.

In Florida the older rent-subsidized population is top heavy "with persons over the age of 75, women, people living alone, and African Americans" (Golant 1999, p. 3). If this group cannot maintain independent living arrangements, they become prime candidates for nursing homes, board and care facilities, or other long-term care options at the expense of federal and state tax dollars. If this population is able to access supportive services and receive assistance from housing managers and sponsors, premature institutionalization can be at least delayed, allowing for elder occupants to age-in-place.

Recent estimates suggest that between 15 and 20% of older people living in low-income housing nationally suffer from some form of frailty (Keen 1997, p. 1; Golant 1999; Winograd et al. 1991. Approximately 14,000 residents in Florida's HUD housing can be classified as frail--that is they are experiencing difficulties taking care of themselves and/or their apartments (Golant 1999). Just these two problems alone, according to housing managers, force tenants to be relocated to more supportive housing environments, especially in those facilities that do not have staff or on-site services to assist elders with their day-to-day lives.

The elders living in government-subsidized housing have a variety of strikes against them. Older people in this type of housing are the poorest and most vulnerable residents in any housing system. Neighboring residents may be disinclined or unable to provide assistance because of their own frailty or lack of community feeling. One might expect housing sponsors or managers to address these shortfalls and problems by helping frail residents to age-in-place, or choose to remain and concentrate in communities and

neighborhoods over time. Indeed, service providers, residents themselves, and families often make the assumption that senior housing includes senior services (Brice & Corey 1991, Merrill & Hunt 1990). In reality, managers and sponsors address a broad array of concerns. Residents coping with their frailties do not always rise to the top of that list.

Historically, federal and state housing policies have held housing sponsors accountable only for physically and fiscally sound dwelling units and have required residents to live independently--a term, that like frailty, has great variation among housing providers as well as state and local governments. These policies have discouraged housing providers from involvement in social service provision and/or access. While studies such as Golant's CASERA Project (1999) indicate that some managers do provide support, assistance is far from universal and tends to be unsystematic. Managers often lack the resources and expertise necessary to ensure quality service and can be just as overwhelmed as residents in attempting to access them.

Measuring Frailty

The term *frail* has become a very highly charged--though imprecisely defined word that is used to describe elders having "deficiencies" that prevent them from safely living alone or performing everyday activities without assistance. Currently, no consensus exists on the best way to define or measure frailty, or its effects on such outcomes as future institutionalization. Various groups of researchers, medical professionals, and social workers--as well as other professionals in the field--all have varying definitions for understanding frailty. For elders in government subsidized housing, frailty has come to mean a lack of access to needed supportive services, particularly transportation, hot meals, housekeeping chores, and other day-to-day

activities. Often with no family to turn to for assistance, frail elders become embedded in a cycle of un-addressed needs that will eventually force them from their affordable rental units.

Frailty of this group is often simply determined by assessment or manifest as ADL (activities of daily living) or IADL (instrumental activities of daily living) deficiencies. These deficiencies are examined in the research of Golant (1999), Winograd et al. (1991, 1988), and Bernstein (1982) as being contributors to the need for supportive services. Many of these elders suffer from deficits that include problems with bathing, toileting, cooking, using the telephone, shopping for personal items, and transportation. Although these impairments may not constitute serious medical conditions, nonetheless, many elders and housing managers consider such impairments to be the basis for judging and defining *frailty*.

The absence of standard measures of frailty creates a variety of difficulties in understanding how frail elders cope day-to-day. Though *frailty* remains an ill-defined term, and is often regarded as a "condition or syndrome," new conceptualizations are emerging. To best grasp frailty--as a concept--it must be understood from the standpoint of the elders and managers. Rather than simply identifying frailty in terms of objectively measured ADL and IADL deficiencies, researchers need to have the "actors" define this term in their own words. To that end, a more insightful examination of frailty demands that the two actors "construct" frailty through conversations. By engaging the issue of frailty in this manner, meaning is attributed to the people involved daily in assessment behavior. Residents and managers must explain and describe events from their own lives

and those of others in the residential facility to clarify issues of frailty, aging-in-place, and other relevant events that influence day-to-day life.

To best understand the issues of aging-in-place and frailty in Florida's government-subsidized housing, this study uses managers and residents' own words to describe their day-to-day situation. To protect their identities, pseudonyms are used throughout this research.

Frail Elders: A Desperate Need for Services

Not surprisingly, much variation exists in the abilities of housing managers and sponsors to offer supportive services to delay low-income, frail elders need for relocation or premature institutionalization (Davis et al. 1998, Griffith et al. 1996, Lane 1995). Similarly, community-based service providers inconsistently provide services to this group (Wolch 1996, Struyk et al. 1989). Exactly how to best provide services to this population continues to be the subject of much debate.

The poor elderly have consistently faced many obstacles trying to lead their day-to-day lives. Before government programs intervened to provide housing and medical assistance, poor seniors had trouble obtaining adequate shelter and healthcare. Though the past decades have seen improvements in the financial status of seniors, particular segments of this population continue to have problems accessing the services needed to maintain health, well-being, and financial independence, especially in times of medical crisis. The poorest of the poor--like those in government subsidized housing--cannot afford to make supportive, home health care arrangements to help with illness, or recovery from surgery.

> When an elderly resident of government housing breaks a hip and must spend months recovering in a rehabilitation center, the housing manager may decide it is

> too costly to keep the patient's apartment vacant and rent to someone else. . . . (Keen, 1997, p. 1)

Because this subgroup has such low income, seemingly minor events become major life-changing catastrophes. Without access to services like housekeeping, transportation, and bathing assistance, people become trapped in their homes fearing management will consider them "unfit" to continue living in their homes. This fear translates into hiding "needs" from friends, family and neighbors until the situation truly requires a more supportive environment. With current state and local supportive service programs, however, this does not have to be the case.

By understanding how issues of frailty, poverty, need for supportive services, and increasing elder populations come together in low-income housing, researchers can better understand how to support this group to age-in-place, or remain in their home as they age. By encouraging this population to "remain at home," and supporting them to "remain at home," premature institutionalization costs can be minimized and quality of life can be maximized.

A Strategy to Deal With Frailty and Service Need

According to Stephen Golant, "Sometimes if an elderly person can receive just a little assistance, perhaps in the form of a personal aide coming to help with grooming or a bath, it may mean the difference between staying in what has become home and having to move out" (Keen 1997, p. 2). Increasingly, as the average age of seniors in HUD subsidized housing has steadily increased, so too has the demand for supportive services. Those without family are especially in need (Golant 1999, Wilson 1998, Lanspery 1997a, 1997b). Without access to supportive services, this group is at much greater risk of having to enter a nursing home. This premature institutionalization not only lowers

quality of life, but could cost taxpayers significantly in the long run, because the occupied beds usually require funding from the federal-state Medicaid program.

Aging-in-place sometimes merely refers to how elders become concentrated in communities and neighborhoods over time. It is, however, also a strategy for dealing with frailty. By encouraging elders to age-in-place in federally subsidized rental housing, managers are better able to help tenants maintain their independence. Morrison (1992) states the following:

> As AIP [aging-in-place] becomes more prevalent and widespread at local scales, significant numbers of older inhabitants will be staying put, living independently as long as they can. Future elder aging in place will express needs in place. Their needs will be met either through various forms of assistance in place or through expenditures in other places (e.g. retirement and nursing homes) where many of today's elderly now live out their dependent years. The latter options are one approached to achieving economies of scale. AIP poses a challenge for the nation to devise additional possibilities and, through research to identify where in space those possibilities might become feasible in the future. (p. 1)

By encouraging aging-in-place, states minimize costs of premature institutionalization.

> A single statistic from a study by the Institute of Medicine dramatizes the massive cost implications of dependency: If it were possible to postpone for one month the onset of disability that leads to an elderly person being placed in a nursing home, the resulting savings would total $3 billion [1991] dollars. (Morrison 1992, p. 2)

The advantages of aging-in-place link together three important criteria: maximum benefit, minimum cost, and maximum quality of life.

Successful aging-in-place (AIP) will occur only where programs maximize the personal dignity and functional independence of the resident being "retained," and only where this person has real housing alternatives that have been fully explored before a choice of "staying put" is made. Furthermore, this will only occur when aging-in-place programs minimize "unnecessary or inappropriate" support. Residents must be encouraged to accomplish tasks on their own, rather than waiting for caretakers to

immediately provide assistance. Only support provided at the margin of need as defined by an individual's personal inclination and efforts to live independently should be offered by aging-in-place programs. Any more or less support undermines the individual's efforts to remain independent (Golant 1991, Golant 1984, Lawton 1989).

For aging-in-place initiatives to really work, a wide variety of housing choices that address the needs of the local aging population and that serves the full continuum form assisted to independent living are necessary. The aging-in-place concept works best as part of a comprehensive approach to support the needs of the frail low-income elders of Florida's government-subsidized housing to age-in-place. This type of program is the most dignified and cost-efficient ways to provide long-term assistance. Too many state and local governments have mistakenly believed that extended family support, minimum-wage home assistance, and occasional professional services are all that are needed to allow frail elders to age-in-place.

Alternative Service Models and the Role of Economies of Scope and Scale

The delivery of supportive services to government-subsidized housing often benefits from two economic principles. The first, economies of scale, relates to the ability to offer a single, low priced service to a specific population. In Florida's government-subsidized housing, an off-site service provider usually does this; however, some facilities are assuming this responsibility on-site. As one manager interviewed for this study explained:

> We have a [community-based] service provider supply service because they can come onto our site and give our residents the service they need at a low price. We rely on ABC Senior Service [not their real name] because they take care of five or six projects in the area, know what they need to do, and give a good price. Our residents are very pleased. (Manager 19)

By providing a single type of service to a large population, delivery costs can be reduced. In turn, this reduction in costs translates into a lower cost to the resident needing services. This economic advantage is highly significant in geographic areas where elder populations are highly concentrated, particularly in south Florida. The second, economies of scope, relates to the ability of a single housing project to provide multiple services to the residents found in one location. Another manager puts it this way:

> [We provide service to our residents because] we can give them the services they need, a price they can afford, and know exactly how to address their changing needs. This is better than bringing someone [on-site] because we are dealing with our own residents. They know me and staff and don't have to worry about having someone unfamiliar in their homes. (Manager 4)

One housing facility is able to harness its staff, knowledge and resources to provide two, three, four, or more services to residents as on-site services.

The term economies of scale embraces a variety of relationships between unit costs of production and the size of the organization producing it. According to the theory of economies of scale, this concentration of elders should allow service providers to deliver services in a cost-efficient manner.

> Proficiency is gained by concentration of effort. If a plant is very small and employs only a small number of workers, each worker will usually have to perform several different jobs in the production process. In doing so he is likely to have to move about the plant, change tools, and so on. Not only are workers not highly specialized but a part of their work time may be realized by expanding the scale of operation. *Thus important savings may be realized by expanding the scale of operation. A larger plant with a larger force may permit each worker to specialize in one job, gaining proficiency and obviating time-consuming interchanges of location and equipment. There naturally will be corresponding reduction in the unit cost of production* [emphasis added]. (Gould & Ferguson 1980, p. 198)

By taking advantage of clustered senior populations, service providers are better able to provide specific services at lower costs. This programmatic advantage fosters aging-in-

place in a greater number of facilities regardless of population or age-density of the facility.

Where economy of scale works to the advantage of community-based supportive service providers to reduce costs when bringing services to residential projects, economy of scope offers cost advantages to the facility sponsors and managers in providing services on-site. These internal economies of scope offer incentives to "providers" that can supply two or more different, related services more inexpensively than in isolation (Malecki 1991). This allows housing projects to offer services, and the possibility of maintaining control over those services, as an on-site profit-making center using current employees. This is important for four key reasons: (1) the variety of services available, including number of each needed service and scheduling, (2) the complexity of needed service (i.e. certified nursing assistant versus skilled nurse), (3) the uncertainty of outside conditions, and (4) the dynamic situation of implementation and control over service provision process (after Hitomi 1989).

Research Objectives

The purpose of this research is to gain a greater understanding and clarification of the meanings both managers and frail elder tenants attribute to frailty and aging-in-place and to explore how these meanings are influenced by their occupied buildings' contexts. These insights are essential because they offer a view of management's attitude and philosophy of aging-in-place--the desirability of helping their older tenants to remain in their current homes--and conversely, the resident's views of the housing manager's policies.

Researchers must find ways to understand better the "triggering" mechanisms used by housing managers to judge relocation decisions for tenants. Similarly, there must be an understanding of the criteria residents use to judge their own abilities to live within the HUD environment. The success of any aging-in-place program in rent-assisted housing rests on the success of avoiding these "triggering" incidents and supporting low-income elders with services to remain in their homes. The major research objectives to be addressed in this study are as follows:

1. To understand how managers and residents define frailty.
2. To understand how managers and residents define aging-in-place.
3. To understand how project size and density influence issues of frailty and aging-in-place.
4. To identify major service delivery models in Florida's government-subsidized housing and how they are linked to economies of scope and scale.

To address these questions and best understand the data, a qualitative methodological approach was undertaken. The strongest "reason" for using this orientation method is that it allows the researcher the ability to "detect, represent, and explicate the meaning" of each individual's meaning of frailty and aging-in-place (Sankar & Gubrium 1994). Qualitative methods function best

> in situations where variables are unknown, where cultural issues are key, where it is important to understand the texture of differences within the study population, where the focus is on the dynamics of a situation or the development of a relationship, or where the very meaning or definition of issues under study is unknown or not agreed upon, then qualitative research can bring clarity and understanding through its attention to meaning, process, and context. In particular, its flexibility and sensitivity to process allow it to respond to issues and directions that emerge in the course of the research. This includes attention through all states of the research, from design to analysis to the interaction between researcher, informant, and research context as a source of data. (Gubrium & Sankar 1994, p. x)

The use of this methodology is important in gaining a unique perspective of the process and situation of the participants surrounding and structuring these aging-in-place and

frailty issues in the context of congruence in Florida's HUD housing facilities. By learning about these issues from the actors--in their own words--we gain insight into the narrative of people "constructing meanings" of the issues at hand. To support the qualitative data interpretation, I used the computer program NUD·IST to search and structure the "talk database" (Gahan & Hannibal 1998, Denezin & Lincoln 1994, Miles & Huberman 1994) looking for common meanings, ideas and categories for aging-in-place and frailty. In addition to the flexibility in coding the interview transcripts, the strengths of this program allow for the creation and management of ideas and categories found within them. The NUD·IST program functions well for clerical maintenance, and allows the data to be manipulated to "uncover" alternative and "new" views in the interview records. The primary qualitative data will be supplemented by an examination of secondary data generated by gerontological and geriatric researchers, senior housing researchers, and policy makers at state and national levels.

Impact of the Project

The results of this project are expected to produce the following programmatic impacts:

- A more complete understanding and definition of frailty from managers and residents of Florida's low-income, government-subsidized housing projects.
- A more complete understanding and definition of aging-in-place from managers and residents of Florida's low-income, government-subsidized housing projects.
- A better understanding of the relationship between project size and density and how these factors influence issues of frailty and aging-in-place.
- A better understanding of the role of economies of scope and scale in supportive service models of Florida's low-income, government-subsidized housing projects.

Dissertation Outline

Chapter 2 develops the conceptual framework and methodology for this study. Chapter 3 presents the conditions in Florida's low-income, subsidized public housing, issues regarding supportive service programs, including the service coordinator and the congregate housing services programs (CHSP). Interview data are analyzed in Chapters 4, 5, and 6. I attempted to link the interview data with the evidence presented in Chapters 2 and 3. Chapter 4 examines the social construction of aging-in-place as developed through the interviews with the 48 managers/sponsors and the 105 residents. Chapter 5 examines the social construction of frailty in the same manner. Chapter 6 examines the impact of economies of scope and scale on environmental supports, noting the positive correlation between high concentrations of elders and the availability of supportive services. Lastly, Chapter 7 summarizes the approach and findings of this research.

CHAPTER 2
CONCEPTUAL FRAMEWORK AND METHODOLOGY

We shape our dwellings and afterwards our dwellings shape us.
Winston Churchill

Conceptual Framework

An important mission of this research project is to understand the mechanisms used by managers to decide when to move low-income, frail residents out of their housing complexes. To adequately understand these mechanisms, it becomes important to access personal conceptions of *frailty* and *aging-in-place*. The strategies to access and understand these concepts require comprehension of the following:

- Environmental congruence
- Transactionalism and the Transactionalist approach to understanding frailty
- Theories of competence: environmental impact

Social and Behavioral Science Models

Housing for low-income elderly is an important yet unappreciated issue confronting state and local governments.

> Older persons place special importance on housing because they are likely to spend more time in it, have more difficulty taking care of it, and have stronger psychological attachments to it (having lived in the same place for many years). . . . (Pynoos & Regnier 1991, p. 91)

If there is a poor fit between the capabilities of older persons and their environments, daily life activities may change unnecessarily or dangerously contributing to accidents, isolation, and premature institutionalization (Pynoos & Regnier 1991).

Traditionally, understanding the human-environment relationships has been based on environment-behavior interactional approaches employed by psychologists (Golledge & Stimson 1997, McAndrew 1983, Lawton and Nahemow 1973). Recently, some of the most useful models have expanded upon classical competence models seeking individual assessments of environmental congruence, and other issues of personal need in individual space (Golant 1991, Parmelee & Lawton 1990).

By taking traditional competence models, their refinements over time, and the potential offered through qualitative interviews, an in-depth understanding of the relationship of an individual to his or her environment can be better understood. Undertaking this investigation within the context of Florida's government subsidized housing for seniors provides insight into the issues of frailty and aging-in-place.

Environmental Congruence: "Constructing" Low-Income Housing Environments

With current trends in aging in the United States, researchers, over the last three decades, have demonstrated a great interest in assessing and matching planned housing facilities with the needs of older Americans. In fact, this match--or congruence--between lifestyles and the needs of older people and the supportive nature of housing facilities for facilitating aging-in-place, directly influences the success, well being, and quality of life of residents will experience in their housing environment. By examining the interaction between residents, managers, and the environment it is possible to gain insight into the quality and appropriateness of the supportive residential environment for aging-in-place. One of the key approaches to understanding the residential facility's appropriateness is found by examining the supportive services available to frail elders.

By their very nature, well-run facilities will attract a specific type of resident desiring the services, amenities, and management style offered by that specific building (Golant 1984). As a consequence, a residential facility is often homogeneous in terms of the population's profile and needs. Once potential clients have become residents, they have a role in shaping and modifying that residential environment. Inhabitants and management of a congregate housing facility attempt to maintain the set of living patterns and environmental qualities that existed on move-in (Golant 1991, Barker 1968). They hope that maintaining similarity in lifestyles and activities will contribute to high satisfaction with the surroundings, enhancing quality of life and, ultimately, contributing to successful aging-in-place. If the facility loses homogeneity, the potential mismatch between residents and their environment could create dissonance in the residential living patterns of the facility

Like residents, management, too, have a part in the formation and construction of this environment. Regularly they are faced with decisions to transition residents to a more supportive environment, allow more supportive services into the building, create in-house support systems, or simply evict residents that no longer abide by the terms and conditions of the lease. Additionally, management has a vested interest in maintaining the homogeneity of the facility's lifestyle and services. By attempting to satisfy too broad a spectrum of needs, management faces a future of increasing costs, ultimately cutting into the ever-important "bottom line" needed to successfully maintain any housing facility. Too diverse a population increases the likelihood of a schism erupting between different groups of tenants and creating an untenable situation as the manager attempts to cope with the needs and desires of various splintered groups of residents.

Within the context of a facility's housing environment, both residents and management are interdependent factors in the creation of a building's environment.

Attempting to understand this transactional relationship between managers and residents is one basis for investigating the appropriateness of the supportive aspects of residential settings for both homogeneous and heterogeneous populations (Golant 1991). Elements of mis-match or congruence in a residential environment can be varied--services needs and delivery, management style, quality of life, and perceptions of frailty to name a few. Individually, each of the factors proves important, but does not "construct" a congruent or mis-matched environment. Taken together, however, these elements create a strong case for understanding the appropriateness of the environment in relation to the tenants and manager.

Transactionalism: A Way to Understand the World

A central concept for understanding the dynamics of the resident/manager relationship--generically classified as a person-environment relationship--is *transactionalism* (Altman & Rogoff 1987, Wicker 1982). According to this paradigm (see Figure 2.1), people and their psychological processes are embedded in physical and social contexts (Altman & Rogoff 1987, Werner et al. 1985). Within the bounded and ordered system of the rent-subsidized housing facility, people and "non-human components [act and interact] to carry out an ordered sequence of events" (Wicker 1982, p. 12). Thus, the residential setting is the slate (which could be anywhere) on which scenes of life (of anything) are played out. The interactions of people, behavior, places, and temporal dynamics combine to take on specific meanings in specific locations under specific conditions and at specific times. These events --in turn--define future events to

Components	Stability	Focus	View	Patterns
Holistic entities composed of "aspects," not separate parts of elements; aspects are mutually defining; temporal qualities are intrinsic features of wholes.	Changes are intrinsic and defining features of psychological phenomena; change occurs continuously; directions of change are emergent and not pre-established.	Emphasizes *formal* causes, i.e. descriptions and understanding of patterns, shapes, and form of phenomena.	Relative observers are aspects of phenomena; observers in different "locations" (physical and psychological) yield different information about phenomena.	Focus on event, i.e. confluence of people, space, and time; describe and understand patterning and form of events; openness to seeking general principles but primary interest in accounting for event; pragmatic application of principles and laws as appropriate to situation; openness to emergent explanatory principles; prediction acceptable, but not necessary.

Table 2.1. Transactional Axioms. Adapted from Altman & Rogoff 1987, p. 67.

create a collective assemblage of behaviors for a setting. The timing, events, and elements of a particular residential facility combine with the psychological and social transactions of the residents and management to constantly change the dynamics of the facility.

Transactionally, the processes that are occurring in the HUD-subsidized residential facilities create and reflect an intra-facility sense of meaning regarding frailty and aging-in-place. These meanings occur at the level of action and at the level of meaning; they can be events, activities, meanings, evaluations, or any other psychological process. The key element that makes them transactional is that the environment is as much changed by the behavior as often as the behavior is changed by the environment.

When examining the relationship between managers and residents transactionally, both groups become active elements in creating and defining the residential environment.

The transformations in the environment these two groups bring about, change not only daily, but moment-to-moment. The characteristics, as interpreted by managers and residents, become an ever-changing canvas that cannot--therefore--be pre-established or pre-determined. The crux of this research centers on the notion that observers and participants in the constant re-creation of the residential environment can--and do--have different information about the environment, depending upon their location, attachment, and perspective. Each person "shapes" or constructs the environment to fit his or her own purpose.

A transactionalist approach views the phenomenon of the person-environment relationship as a holistic entity--a complete set of actions occurring in a physical setting that cannot be separated without destroying meaning. At any facility, the residents interact with an environment created not only by physical characteristics of the surroundings, but manager and situational-created as well. This same coping process is replicated in the ever-changing environment created by residents for the management and staff to negotiate. After all, this is the major focus of any residential facility's management and residents--to create and maintain a congruent type of environment. A problem arises when residents' declining competence levels create an ever-increasing gap among the varying abilities of residents. The variability of competence levels--while being a broad spectrum--can be classified in terms of age, ability, health, and supportive service utilization. Frailty--in this research--becomes one of the most important dimensions.

Understanding Frailty from the Transactionalist Perspective

To understand frailty transactionally, researchers must break away from the traditional medical model that shape's society's view of frailty. It must be understood that frailty "is a condition that resides *within* the individual rather than a situation which exists *for* an individual" (Raphael, Cava, Brown, et al. 1998, p. 2). Accepting this definition, allows elders to create and define their own conceptualization of frailty, rather than simply being labeled with it. This definition can be changed or modified as they encounter events, activities, and meanings that shift their perceptions either positively with supportive services, or negatively with a senior-unfriendly physical plant. The variability of this definition can be significantly influenced by the supportive nature of the residential housing environment.

Understanding Aging-in-Place from the Transactionalist Perspective

The nature of aging-in-place, too, functions transactionally because of the changeability exhibited by interactions between residents and management within the facility's environment. As these two groups interact to construct the residential environment, factors influencing the ability to remain in the complex change the likelihood of aging-in-place. For example, if services such as housekeeping and transportation are incorporated into the complex, elders may be able to remain in their apartments years longer before needing a more supportive housing situation. The potential for change becomes the constant elements. Meanings for aging-in-place, like that of frailty, are found in the context of the residential housing environment, and that environment itself is continually changing.

Theories of Competence in Environmental Impact

In the last twenty years, researchers have come to realize the importance of not just the physical components of housing--i.e. design features--but the role of the broader contexts of the constituent elements of the environment in which the dwelling exists (Golant 1992, Golant 1991). Thus, in addition to the traditional notions of "environment" like the physical conditions of the building, its location, and its proximity to recreational and commercial facilities, the access to supportive services becomes key in "constructing" an environment allowing seniors to age-in-place. An understanding of what it means to be competent, thus requires an appreciation of how environments are interpreted differently by low-income, frail elders. Two hypotheses, developed by Lawton et al. (1984) offer insights into how environmental meanings define individual competence.

The *environmental docility hypothesis* argues that as the competence of older persons decline, a greater proportion of their behavioral outcomes will be explained by the attributes of their environment. Golant (1991) highlights as an example what one elder might believe ". . . because I am frail, I am less willing to risk falling on a slippery sidewalk after it rains; consequently [frail elders choose to] remain in [their] houses until the sidewalk dries" (p. 32). This person does not want to risk an accident, a possible broken arm or leg, and an ambulance ride to the emergency room. She lets the environment dictate her actions so that she may remain safe. The greater the environmental barriers, the lower the individual's ability to meet the challenges of the environment. Supportive services provided to these types of individuals would offset the fears generated by unstable environmental assessments. Other manifestations of this hypothesis are found in residents from these complexes range from talking about not

leaving apartments for fear of crime, to avoiding showers or bathing because of fears of falling.

The *environmental proactivity hypothesis* argues that the environment provides more opportunities to realize the goals and needs for individuals who are more competent. People with higher competence are seen as having more ways to manipulate surroundings to one's own advantages. Wilson (1998b) recounts in the Orlando Village interviews that one resident "was more willing to leave her apartment to travel to the grocery store, drug store, and doctor's appointments after the bus started picking up residents in front of the housing project" (p. 11). Supportive services brought residents back to daily life activities because they became more confident in themselves and their abilities.

Difficulties Assessing Supportive and Unsupportive Environments

Though these two hypotheses appear straightforward, they mask the complexities of trying to achieve residential environments that match the needs of elder residents. Management and support staff may create environments that are too supportive and overly responsive to residents' needs. Indeed, transactional circumstances can and will be interpreted differently among residents and management. It is argued that in environments that are too supportive, those with high competency levels cannot exercise and maintain needed life skills (Lawton 1985), a subtle encouragement toward *passive contentment* is reinforced (Golant 1991, p. 33).

> . . . Simply helping people may make them incompetent. While meaning well, it communicates to the persons that he or she is not able to do whatever it is for him- or herself. If the person faces no difficulty, if there are no challenges, large or small, feelings of mastery are precluded and consequences such as involution, depression, and premature death are real possibilities rather than mere exaggeration. Helping the resident to get dressed to go to breakfast (either out of

> concern for the resident or to save time for the staff) may only result in feelings of incompetence and dependence for the resident and ultimately take more of the staff's time, since the individual will soon come to assume the need for such help. (Golant 1991, p. 33)

On the other hand, too autonomous an environment leaves the most frail and vulnerable without the supports needed to maintain a high quality of life and completely negates the major reasons for moving into more supportive residential surroundings. Any action to accommodate one group over another has the potential to upset the delicate balance of the residential facility and reinforce the division between residents.

This is argued by Lemke & Moos (1989) when they propose that "high functioning residents are more active in settings where other residents are active, functionally able, and have more social resources and where autonomy is greater," whereas the "very impaired residents in such settings may experience negative effects of a too demanding environment. With reduction in their self-initiated activity to below the level found for similarly impaired residents in a less demanding environment" (S146).

The insights offered by these hypotheses help shed light on how managers and frail, low-income residents of Florida's subsidized housing interact to construct the residential environment. It will be possible to discern better the influences of the transactional environment on supporting frail residents to remain at the facility, or forcing them to move to a more supportive environment. Attempting to understand the residential environment and the relationship between managers and residents in this manner allows a greater understanding of the "triggering" mechanisms that force elders to move in the first place.

The Larger Environmental Context: Frailty and Aging-in-Place

It is expected that both elder and manager and sponsor's interpretations of frailty and aging-in-place are at least in part a function of both the age-density of the project, the overall number of elder tenants, and the particular HUD funding category of the facility. These three characteristics are influential because the facility shapes the expectations of management. Managers that are accustomed to dealing with elders, and their problems, probably have experiences in places like Section 202s, specific training, and an understanding of the available services required by and available to the elder population. Due to the nature and characteristics of each facility type (see Appendix A), the housing environment will variously offer levels of supportive services (see Table 2.2).

Section 202s offer the greatest likelihood for supporting aging-in-place of low-income, frail elders with supportive services like personal care, health services, transportation, and meals. Sponsors of this type of housing are often private nonprofit organizations. While targeted to seniors, occupants can include nonelderly disabled tenants (who occupied these apartments before 1990). Many of the projects provide congregate common areas like dining rooms, community rooms, and libraries; as well as supportive services. The other housing types, not only often lack supportive services and design modifications, but also are more likely to have highly heterogeneous populations that will contribute to increased supportive service costs. Section 8 non-insured facilities assist very low-income groups with no restrictions on age. These projects were designed both to assist tenants with income too low to obtain decent rental housing in the private market and to encourage new construction. Similar to Section 8s are Section 221 (d) (3) and (d) (4) buildings that assist all groups of people regardless of income limits. The principal difference between (d) (3) and (d) (4) programs is the amount of insured

mortgage available to nonprofit and for-profit sponsors. Section 236 facilities offer a clear difference from Section 221s and Section 8s, in that they can include self-contained apartments, congregate facilities, or a combination of the two. They can also have on-site dining halls, community rooms, and healthcare services. Perhaps the biggest limitation of these projects is the smaller rent revenues. They severely restrict the operating budgets of facilities and, in turn, the resources that can be allocated to staffing and services.

	Section 202	**Section 236**	**Section 221**	**Section 8**
Supportive Services Available	Yes, most supportive of these four housing types. Usually on-site and community-based services.	Limited supportive services available--usually offsite.	Limited supportive services available--usually offsite.	No services available. Services may be available in the community.
Target Population	Elders only.	All age groups. Individuals and families needing housing.	All age groups. Individuals and families needing housing.	All age groups. Individuals and families needing housing.
Heterogeneous Population	No, elderly only.	Yes	Yes	Yes
Income Limits	Low-income	Low-income	Low-income	Very low income
Service Coordinator	Yes	No	No	No
Physical Plant Modifications to Assist Elderly and Disabled	Yes, beyond those required by the Americans with Disabilities Act (ADA).	Only required to be ADA compliant.	Only required to be ADA compliant.	Only required to be ADA compliant.
Congregate Areas	Yes	Yes	No	No
Sponsor Type	Usually non-profit.	Profit and non-profit.	Profit and non-profit.	Profit and non-profit.

Table 2.2. Government-Subsidized Housing Types and Characteristics.

The advantages of Section 202s over other housing types hinge on their ability to generate economies of scope and scale. It is expected that high concentrations and populations of elder tenants will allow economies of scale and scope to decrease supportive service costs, yielding a more regular and consistent delivery. For this housing type, economies of scale allows a single, lower cost service to be brought on-site from community-based providers--maximizing the cost per service expense ratio. For facilities with the ability to offer multiple services on-site--economy of scope allows multiple services, usually three, four, or five, to be supplied on-site with significant cost benefit to the tenants.

When services are delivered to an elder-occupied building with a combination of high population/high concentration low-income, elder housing, a two-fold benefit can be realized. First, housing managers can provide supportive services more cheaply to elders in need. Managers in effect "gain more time" to devote to physical plant matters, staffing, and overall facility maintenance. Second, service providers can offer a variety of lower cost services to larger numbers of residents at lower prices.

In settings where this occurs, managers and residents may be less likely to view ADL and IADL deficits as "triggers" for relocation. Other benefits of elder population concentrations include facilities specifically "designed" for elders, better trained managers and support staff, and more supportive facilities for aging-in-place. Conversely, however, where population numbers and concentrations are low, or facilities do not directly support elders, service provision costs could be prohibitive, limiting the aging-in-place prospects for this population. In both cases, frailty becomes the key identifier for triggering relocation and limiting the prospects for aging-in-place.

Preliminary Findings: The Florida Village Case Study

Earlier preliminary research (1998) in a Florida HUD subsidized housing facility illustrates how a disparity can occur between management and residents' views of the housing environment. Florida Village is a fourteen story, 197 apartment high rise building with on-site wellness and health centers, library, chapel, and other recreational rooms for crafts, activities, and meetings. At the time of the interviews in 1998, there were 235 residents (288 maximum) living in the non-profit facility with all units occupied. The current waiting list for this facility was six to nine months. According to management, the average age of residents in the facility was 76.5 years old with residents ranging from the mid-sixties to the upper nineties. The inquiry demonstrated a case of *environmental mismatch*, or lack of congruence. Residents and management each had a different conception of the "best" residential environment. Each saw problems in how the actions of others were influencing the housing environment and changing the demeanor of the project. By failing to agree on how to best create and maintain the ideal housing environment, neither group was satisfied.

Interviews with residents and management--both with "good" intentions--sought different avenues to satisfy wants and desires of daily living. The two groups of residents--the young-old (under age 75) and the old-old (age 75 and older)--sought to define environments that maximized their potential. The young-olds sought an emphasis on amenities and services that addressed active retirees, primarily centering on independence with little or no oversight. The old-olds sought a highly supportive environment that provided supportive services, healthcare, and a service coordinator to ensure safe, long-term residency. These polarized groups had very little understanding of

the other's perspective, much less a realization of the benefits each group had to offer to the overall creation of the Florida Village environment.

The active, independent residents of the young-old group were fearful that management was changing the demeanor of the facility by addressing too many needs of frail, dependent elders living in the project.

> **Resident**: He [Florida Village Manager] is changing things too much. He is making this place like a nursing home . . . a morgue. Suddenly, we are all on death watch. . . . I didn't move here to be watched over . . . to live with my mother. They [frail residents] need to realize this place is for people who can do things . . . who have a life. (Florida Village Resident 3)

Similar comments come from other residents, feeling that they are being "squeezed out" by service dependent tenants.

> **Resident**: I think it's good to help the others in this apartment building, but it is too much for them and not enough for us. We need other things around here, too. More things than just service, programs, canes and walkers. We [a resident committee] have suggested that improvements in the lobby, library, and rec[reation] room be considered. The manager has said they will be considered, but that there are other priorities. Huh, I know what those priorities are . . . keeping *them* happy. (Florida Village Resident 7)

This group of residents--the young-old group--worry that the long-term population group-- the old-old--have too much of an influence in creating and maintaining *their* ideal environment. By creating too supportive of an environment, some resident worry that people will become complacent and service dependent.

> **Resident**: If we can get things . . . meals . . . delivered to our apartments . . . that prescriptions can be picked for us . . . that we never *have* to leave our apartments, what is the incentive to live. I don't want to live like a china doll packed away in some cabinet. I don't just want to be taken out on some special occasion. I'm here to live the best way I know how. It's how I want to live. It's how I'm going to live. (Florida Village Resident 9)

The young-old residents fear that the changing residential environment will change the way they want to live, change their lives from active, independent seniors into service dependent shut-ins that have no life outside of the building.

The old-old group viewed their predicament much differently. "I am still independent, but I need help. I want help" (Florida Village Resident 6). Many of the members of this group were long-time residents of the building and had close ties to the manager and his staff. They expected him to help them stay in their apartments.

> **Resident**: We've been here a long time. My wife and I want to continue living here. Granted, we need some help doing things . . . maybe we get some considerations from [manager], but we are living our lives just fine. I know that Bob, Anna, Tim [not their real names] have said things about us and others. There's nothing wrong getting a little help to stay here. (Florida Village Resident 5)

If anything, this group felt that more services needed to be brought into the building to help buttress changes in their lives. This group challenged the younger residents to realize that more services, like transportation and continued supervision and assistance by a service coordinator, would make Florida Village a better and safer place to live. The old-old residents believed that in the long run these services would help the other group (young-old) to stay in Florida Village, too.

The manager of Florida Village was caught in the middle. No matter which group's needs he tried to address, he was likely to alienate the other.

> **Manager**: Residents don't realize that we [management] have a difficult job trying to juggle [building] costs, recreation, health services, and other needed things all the while maintaining high-quality surroundings and care. (Florida Village Manager 1)

One key weakness in this housing project was that the manager did not have a clear concept of the role of supportive services in addressing needs of the residents. Instead, he tried to "play the politician" and be all things to all people. The reality of this

situation was that a congruent housing environment could be created in this manner. Instead, this manager and his staff needed to set out clear service priorities and strike middle ground to create a strong, supportive environment with clear demarcations when residents needed to move to other surroundings.

Attempting to create congruent housing environments is difficult and can come apart at a variety of seams--physical plant, supportive services, recreational or social activity issues. Residents should be able to influence the "residential environment," but it is up to the manager to unify the various groups' environmental perceptions to meet the needs of the majority of residents. No view is more right than another, but in order to have successful residential environments, management must build a consensus among the residential factions.

Unfortunately, management did not present a unified perspective that had clear objectives to satisfy not only residents' needs, but also "bricks and mortar" issues, financial obligations, and federal, state, and local housing guidelines. Not surprisingly, the residents' perspectives break along age-lines. Needs of these two groups--recognized in this research as the young-old and old-old--create unique age-graded desires. By discussing desires with these two groups--through formal and informal interviews--research uncovered a highly diverse population that for the young-old group sought more autonomy and control over events at the facility; while on the other hand the old-old preferred management to "run things" as they saw fit. From this perspective, each individual's influence on the "goodness of fit" in the congregate environment becomes clear. Golant (1991) notes:

> The congregate housing experience has variously been linked to: a person's willingness to association with persons of similar social identity . . . patterns of age identification . . . individual needs for privacy, control, and order. . . . (p. 34)

Without understanding or appreciating the *other's* perspective, management and residents have created an environment that offered inadequate benefits to both groups. The young-old group did not want their complex catering to the most disabled segment of the population for fear that the it would become over-medicalized, changing the residential character. The old-old group sought a more supportive environment that could "encourage" them to do more, while choosing to let the manager make the decisions about how the facility would be run in the day-to-day scheme. Management sought a supportive environment that would engage all residents. No single group of actors in this case was happy with the direction the HUD facility was going.

Research Methodology

Target Population and Site Selection

This research project will focus on two groups of participants: (1) 48 on-site managers/sponsors of Florida's subsidized housing facilities and (2) residents (age 62 years and older) living in these facilities. Managers are most influential in the decisions regarding the transfer of frail, low-income residents to more supportive surroundings and have the greatest influence in the "construction" of the building's residential environment. This case study sets the stage for a greater understanding of how management perceives their residents along two key dimensions: frailty and aging-in-place. By understanding how management acts upon these perceptions, there can be a better understanding of how to support and maintain frail residents in their homes, as well as understanding how they perceive themselves and their place in the housing

environment. The second study group is comprised of 105 elder low-income tenants from the same regions and facilities. Though managers have a greater influence in the "decision making" of the housing project, residents have equally important influences in the maintenance of the project's demeanor and shaping housing policies. A minimum of two residents were interviewed from each facility.

Both groups' participants were selected from the CASERA Project database (Golant 1999), recommendations of the housing manager/sponsor, or as a result of residents encountered in common areas of the facility. For this research, N = 105 residents and N = 48 managers/sponsors. Only those managers and residents who indicated a willingness to participate in future research projects were contacted. The members of these two groups participated in individual qualitative interviews regarding their own conceptualization of aging-in-place and frailty issues.

Site-Selection Criteria

According to the CASERA Project database, there are over 500 HUD housing facilities created under these programs in the state of Florida (Golant 1999). Because of the characteristics of each of the HUD facilities--i.e. Section 8, Section 202, Section 236, and others--deciding how to select the housing facility types to be included in this research was straightforward. To best understand the issues associated with aging-in-place, frailty, and access to supportive services, the housing projects, management, and the residents needed to be compared along specific dimensions. The matrix in Figure 3.2 depicts the site selection criteria for this project. This classification is based on two dimensions by which HUD buildings can be distinguished--age density and number of elderly tenants. Each cell represents a unique category of subsidized rental housing, associated with a unique set of conditions for the frail elder residents. Different

supportive service issues in each housing type--and, therefore, each cell--lend themselves to different supportive service interventions to facilitate the aging-in-place of their residents.

Age Density

Number of Elderly Tenants	Low	High	Total
Larger	12 Non-202s	6 Non-202s 6 Section 202s	24 sites
Smaller	4 Non-202s	10 Non-202s 10 Section 202s	24 Sites
Total	16 Sites	32 Sites	48 Sites

Table 2.3. Site Selection Criteria.

For this research, small population sites will be defined as having less than fifty frail elderly tenants and large as having over 100 frail elderly tenants. High age-density facilities will be defined as having 80% or greater elder concentrations. Low age-density facilities have 40% or less

A total of 48 sites were visited based on the criteria in Figure 2.2. Thirty-two of the facilities were high age-density (HiAD)--this larger group was stratified into larger and small numbers of elderly tenants in both Section 202s and non-Section 202s. Sixteen facilities were low age-density (LoAD), and these two subgroups of non-Section 202s were further stratified into facilities with large and small elderly populations.

Section 202 facilities, i.e. the category of housing facilities that are specifically and solely designed to provide supportive housing to elders (62 years of age and older), were selected as the baseline project category against which other projects would be evaluated (Appendix B). Based on the Florida Village case study and the CASERA Project data, Section 202 housing *should* provide the maximum supportive environment

for elders, including programs such as service coordination, meals, and recreational activities. Also, these facilities would provide the greatest level of support for aging-in-place with highly trained management and staff that could deal with the conditions and problems of an aging population.

In contrast to the high levels of support offered by Section 202 housing, the other housing programs like Section 8 Noninsured, Section 221 (d) (3) and (d) (4), and Section 236 (see Appendix B for full explanations of housing types) do not offer consistently the types of design modifications, services, and other amenities to help frail elders to age-in-place. Additionally, non-Section 202 housing environments often do not benefit from economies of scale, thus, limiting the feasibility of delivering low cost services. This is because they are not entirely dedicated to an elderly population. For example, Section 8 Noninsured combines a variety of populations--young, old, families with children, and other groups--all of which have very different lifestyles and day-to-day needs. They also are less likely to have the physical infrastructure (e.g. dining room, rooms for health check ups, etc) to support aging-in-place responses.

All sites in the research project were from cities and counties north of Lake Okeechobee in four broadly defined areas of the state: panhandle, north, central, and south central. HUD housing facilities south of this lake were eliminated for three key reasons: (1) project expeditiousness, (2) minimization of costs, and (3) elimination of the language and translation barriers.

Major Constructs and Data

Primary Data

Primary data were obtained through the use of open-ended, qualitative, individual interviews with both HUD managers/sponsors and elder tenants. This technique has been proven successful at probing how these actors construct meaning, structure their world within the HUD housing facilities, and make sense of their day-to-day lives regarding the concepts raised by this research (Wilson 1998b, Gubrium & Holstein 1997, Cresswell 1994, Denzin & Lincoln 1994, Gubrium & Sankar 1994, Kaufman 1994, Miles & Huberman 1994).

Secondary data used in this research project were compiled from the CASERA database; specifically the age density of the Florida subsidized housing facilities, the project manager contacts list, and the facility frailty percentages. The secondary data was used in the initial selection of projects and provided a backdrop against which frailty and age-density percentages were judged.

Aging-in-place

Aging-in-place, or assisting older people in maintaining their residence as they grow frail and impaired has become one of the primary missions of the aging establishment. This term--highly variable in its definition--is expressed in written documents and everyday policies and action of a housing facility's management team, as well as by the lifestyle and beliefs of the residents themselves.

Managers will be asked a series of questions that examine their aging-in-place philosophy of the housing facility, physical infrastructure, on-site and delivered supportive service programs, and other practices that contribute to elders remaining on-site. From these responses, an understanding can be achieved not just how the manager

feels about aging-in-place and frailty, but how these feelings are turned into actions within the project.

Elder residents, on the other hand, will be questioned regarding their personal feelings toward aging-in-place, and the availability of both informal personal assistance and community-based supportive service resources. Much like the managers, elder tenants' responses will be examined to understand how they put their beliefs and attitudes into everyday coping behaviors in the facility.

Frailty

Though frailty is often conceived in medical terms, this study seeks to understand how residents and managers define frailty themselves--how they live with it, how it is defined by them, and sometimes imposed on them. By looking to understand frailty from this perspective, it becomes more than simply objectively measured ADLs, or functional limitations, or a medical report. Rather, frailty becomes personalized and identified by those having to live and deal with it every day.

Qualitative Data Analysis

The meanings that managers and elderly tenants give to frailty and aging-in-place are key aspects of this research and will be assessed through qualitative open-ended interviews. To that end, this research seeks to identify and describe patterns and themes that center on the themes of frailty and aging-in-place as two key elements of the HUD subsidized housing experience.

Interviews with management/sponsors and frail elder residents were coded and analyzed manually and with the computer program NUD·IST searching for key words and phrases relevant to each individual's "construction" of the conceptions of aging-in-place, frailty, supportive service utilization, and related beliefs.

Managers will be questioned about their facility's frail elder tenant supportive service policy and the methods of identifying and defining *frailty*. Elder residents will be asked a series of questions on self-estimated frailty and dependence.

Throughout the process of data organization, the data was re-examined and re-coded as more interviews were completed and new avenues of interest were uncovered. At the conclusions of interviews in April 2000, a list of "major ideas" was compiled to provide a reference chart of interview data. In addition to the manual coding, the data analysis process was aided by the use of a qualitative data analysis compute program called NUD·IST. By utilizing the computer program, the researcher was able to directly enter elements from the field into a database that could organized and re-organized, and re-assembled into meaningful chunks of information for interpretation. At a later time, these "chunks of data" could be categorized and coded to provide insight into the social construction of the two variables.

The primary strategies utilized in this research to ensure external validity are: (1) thick, detailed descriptions so that anyone interested in transferability will have a framework for comparison, and (2) data collection and analysis strategies will be reported in detail to provide a clear and accurate picture of the methods used in this inquiry.

CHAPTER 3
MANAGEMENT AND FRAIL ELDER TENANTS IN FLORIDA'S LOW-INCOME, RENT-SUBSIDIZED HOUSING: A LITERATURE REVIEW

Florida's government-subsidized housing managers and their senior tenants confront a variety of obstacles every day trying to access services, maintain independence, and secure funding for continued programmatic support. These problems arise not only out of state or local interests, but national ones, as well. Understanding how these needs, and the issues of frailty and supportive services come together, allow for a greater understanding of aging-in-place in Florida's low-income senior population.

Until the research of the CASERA Project (Golant 1999), much of this problem was inadequately understood to render intelligent commentary. This study is much more than understanding concentrations of elders in particular types of housing facilities. Only upon closer examination can the numbers reveal the unequal presence of affordable units across Florida. According to Golant (1999), understanding *this* pattern of unmet need and the opportunities for cost-effective service delivery are central findings of the research. First, it indicates the extent to which certain locations in the state are without an equal share of affordable elder housing relative to the size of the at-risk, low-income population. Second, the extent to which facilities are found in a relatively few locations and administered by a few sponsors/owners, there is an increase in the chances that economies of scope and/or scale might be achievable when it comes to supportive service delivery. In areas where these economies are not achievable--in dispersed and isolated locations or low population numbers--the service costs tend to be higher. In turn,

services are likely to be delivered less frequently. Understanding the potential benefits of concentrating populations to take advantage of low-cost services, more frequent delivery, and the potential for co-location of offices and clinics highlight the advantageous nature of economies of scale.

To understand the full scope of Florida's government-subsidized housing situation, national, state, and local contexts must be examined closely to reveal the critical elements of this problem.

Rent-Subsidized Housing and the Frail Elder Resident

According to the U. S. Department of Housing and Urban Development (2000), the elders assisted by their program number approximately 1.6 million persons. These elders are living in HUD-assisted housing, housing covered by HUD mortgage insurance, rental assistance, or other housing services. An additional 102,000 elderly persons in rural communities are served by what are essentially parallel programs on the Farmers Home Administration (FmHA) side of the assistance equation. During the 1960s, senior housing programs served a much "younger" senior population--usually younger than sixty-five years of age. Most of this group was in relatively good health. Since the 1970s, however, the average age upon admission to these types of housing have become older and required more personal assistance and help to remain in their independent households. Currently, many residents are in their mid-to-late seventies, and early eighties, when they move into a HUD subsidized housing project. This group is usually described as older and less affluent than their counterparts in the general community. This group also tends to be female and a member of a minority group (HUD 1999, Golant 1999, Wilson 1998b). The trend of this population has been for the average age of the

tenant in HUD housing to increase one year of age for every two and one-half years that passes. As of 1999, HUD estimates the average age of elderly residents in their projects at about 78 years of age.

From the broad view of national statistics, housing providers are faced with residents that have--or likely will have--needs beyond the average elderly population. Issues surrounding frailty become key factors regarding the ability of these seniors to remain in their homes.

Shifts in Housing for Frail Elders

Since the late 1980s, policy began to respond to the changing patterns of living arrangement, housing problems, and project demographic changes by the senior population. During this most recent twenty-year period, several pilot programs for frail elders were developed to link housing and services, modify residential environments, and repair unsafe buildings. Major legislation was also passed to make housing more accessible to disabled persons, including the elderly. Three key areas have risen from this time period to aid frail elders in their pursuit of housing alternatives--linking housing with services, developing approaches to providing services, and creating environments where frailty is minimized and aging-in-place maximized.

Overall, national and Florida housing policies for the elderly can be divided into two distinct groups: (1) those that seek to establish comprehensive policies of housing and management and (2) those that seek to provide housing for groups that cannot be served by private builders, usually a supplemental policy like vouchers (Pynoos & Liebig 1995, Heidenheimer et al. 1983). Accordingly, the former programs have focused on the housing needs of entire populations of the aged subgroup; the latter on groups unable to

secure housing in the private market usually those sub-populations that end of residing in subsidized housing, i.e. the poor elderly. Typically the United States has been characterized as having supplementary elder housing policies.

Frail elders are likely to require housing that adapts to diminished functioning, reduces social isolation, and offers a range of supportive services (Gall et al. 2000, Golant 1999, Dreyer 1992, Staebler 1991, Clapham & Smith 1990, Pastalan 1990, Golant 1986, Lawton et al. 1985, Lawton 1976, Bennett et al. nd). Housing that is suitable for this group has to focus on low-to moderate-income levels to promote optimal functioning and safety in the residential population (Bechtel 1997, Fonda et al. 1996, Pynoos & Golant 1996, McAndrew 1993, Golant 1992, Pynoos & Regnier, Lawton 1989, Lawton et al 1984). To avoid the harmful effects of relocations (Wilmoth 2000, Golant 1992, Birren et al. 1991), aging-in-place must be encouraged. Currently these objectives can be met through a variety of programs for low-income elders, particularly by connecting seniors with non-institutional alternatives and community supportive services.

The new trends in housing frail elders is to bridge the "traditional gap" between housing and services. This is realized by recognizing that housing is much more than shelter, particularly for special needs populations like frail seniors (Feder et al. 1992, Callahan & Lanspery 1991, Pynoos & Regnier 1991, Bennett et al. nd). Simply reaching this conclusion re-shapes the way researchers, planners, and policy makers approach the long-term housing needs of frail seniors.

The long-standing assumption in the field of elder housing has been that as persons become more frail, they will have to be moved from one housing environment to another to accommodate the changes associates with aging. This assumption has resulted

in the development of a continuum of housing types for persons with different capabilities (Proeger 2000, Pynoos & Golant 1996, Pynoos & Liebig 1995, Golant 1992, Redfoot & Gaberlavage 1991).

> For example, in the United States, the continuum of services persons with increasing service and environmental needs, ranging from single-family homes and apartments, through board and care homes and assisted living, to nursing homes. (Pynoos & Liebig 1995, p. 8)

Those people needing greater assistance with ADLs and IADLs, though requiring assistive services, can live in a variety of settings. This, according to researchers, is becoming more possible due to technological and medical advancements that were once only available in institutional settings. This fact alone has fueled the enormous growth of home health care services and the potential economies of scope and scale surrounding their existence. Older people themselves express a strong desire to age-in-place.

The Elderly in Florida's Rent-Subsidized Housing

The CASERA Project focused on the age 62 and older tenant population in Florida's conventional Public Housing Authority (PHA) and its privately owned multifamily subsidized rental facilities, administered by HUD. These types of housing include Section 202 (including 202 and 236), Section 221, Section noninsured, and Section 236 programs. Golant (1999) highlights the fact that Florida's low-income seniors are not represented equally in these programs--they are found in 38% of the units of PHA facilities, but in 52% of the housing units funded under the multi-family HUD programs. This simple division of the low income elder population speaks volumes as to how and where to target services in the state.

The findings from the CASERA Project (Golant 1999), as they relate to HUD senior housing, highlight the staggering effects of the unequal size and availability of this

type of elder-occupied rental units and the extent to which different organizations own and manage them. Over 75% of the elders served by HUD housing programs live in less than one-third of all sites in Florida. More importantly, however, is the fact that 19% of the HUD facilities are occupied by 100 or more elder-occupied apartments; and about 39% of the HUD facilities are each occupied by as many as 50 elder-occupied apartments.

Regarding this research, these findings indicate that significant elder populations exist in relatively small numbers of projects within the state. Golant's results for the state's elder low-income housing are significant along four key lines: (1) presence of elders in HUD sites, (2) elder concentrations in HUD sites, (3) county locations in which HUD facilities exist, and (4) organizational concentrations of HUD's elderly units.

The presence of elders at HUD sites

Only about 19% of the HUD facilities are each occupied by 100 or more elder-occupied apartments in the state of Florida. And about 39% of the HUD facilities are each occupied by as many as 50 elder occupied apartments. Of the elder-occupied apartments, 75% of these units are found in less than one-third of all the HUD sites. This information highlights the fact that a few select sites are serving high populations of elders.

Elder concentrations at HUD sites

The elders at Florida's HUD sites occupy 52% of the available apartments. These elder-occupied apartments comprise at least 80% of their building's rental units in 44% of the HUD facilities. Not surprisingly, over 84% of all the elder tenants found in Florida's HUD facilities are located in these building sites.

County locations of elders in HUD sites

For elders living in Florida's low-income HUD housing, 91% of the elder-occupied units found in these facilities are located in just 17 counties. This percentage points to the skewed county distribution of these low-income assisted elder renters. These county locations become even more important when compared with the fact that only 69% of Florida's total low-income elderly population (below the 150% poverty level and not in federally subsidized rental facilities) lives in the same 17 counties.

Organizational concentrations of HUD's elderly units

Despite Florida's 67 counties and large low-income elder population, only 16 sponsors/managers own or administer the HUD facilities that represent over 51% of all of HUD's elder occupied units. There are only 45 sponsors/managers administering the HUD facilities that serve 75% of all of HUD's elder occupied units. Conversely, as Golant notes, 123 sponsors/managers are administering the HUD facilities containing about 25% of all of HUD's elder occupied units.

CASERA Project: An Impetus for this Research

The importance of the CASERA Project is that it provides a base line of information for understanding and addressing the situation in Florida's low-income subsidized elders. "With Florida's aging demographics leading the rest of the nation, and with an estimated 80,000 elderly tenants in rent subsidized housing, it is critical to establish service delivery approaches that successfully address the needs of older tenants to age-in-place" (Golant 1999, p. 37). This idea becomes crucial in a state where an ever-larger Medicaid expenditure crisis looms on the horizon. To properly prepare for the demand for services, changes in housing provision, supportive service delivery approaches, and interagency collaboration need to be explored.

The Need for Services in Florida's Subsidized Housing

Florida's aging population--reflecting national patterns--includes significant proportions having functional and supportive service limitations. Of the 80,000 elder persons (62+) in the state's government-subsidized rental housing, managers/sponsors identified small--though significant (from 14% to 17% of senior tenant population)--segments of their population as having critical unmet needs. Most often, according to Golant (1999), these needs included getting assistance to temporarily ill residents, getting assistance with housekeeping chores, affordable self-care, and family member assistance (p. 16). Without these services, residents will likely be moved from subsidized housing into the more supportive environment of a nursing home.

When similar questions were posed to residents, many indicated that support around the home was one of the key services needed. Specifically, residents cited handrails in the bathroom and shower, transportation, housekeeping services, and access to hot meals. Additional questions probing ADL and IADL performance indicated that while many residents (68%) could perform without assistance, roughly one-third of the population would benefit from supportive services.

This evidence suggests that elderly residents in this type of housing may be at increased risk over time because their service needs are not being met. This is especially true because the population at risk lives alone, is poor, and has difficulty accessing the complex bureaucratic community-based human service network. As the widening service gap threatens continued independence and occupancy of subsidized housing apartments, a critical demand for supportive services will arise in Florida government-subsidized housing projects. If these needs are not addressed, this subgroup of elders will have reduced quality of life, and saddling taxpayers with an unnecessary fiscal burden.

Definitions of Frailty

While there is no concrete definition of frailty--medical professionals, gerontologists, and lawyers all differ on the term's conceptualization--HUD defines frailty on the basis of the performance of **Activities of Daily Living** (ADLs). A person who is deficient in three or more ADLs is defined as *frail*. Currently, the frail elderly in HUD-assisted make up less than 10% (HUD 1999), but as many as 30% of the residents are "at-risk" of becoming frail (HUD 1999, Golant 1999). These individuals represent the most important subgroup in terms of policy decisions and it is clear that this group will require additional attention in the near future. Based on these HUD (1999) figures, estimates suggest that as many as 300,000 to 320,000 are deficient nationally in at least one ADL (HUD 1999, see also HUD 1989, Struyk et. al 1989, Struyk 1985). Those who are "near frail" in that they need some assistance to carry out ADLs comprise an additional 365,000 to 400,000 (HUD 1999) elderly tenants. From these figures, future incidents of need could balloon as the Baby Boomers begin to enter old age soon after becoming at-risk of becoming frail and requiring assistive and supportive services. These concerns become very important for states like Florida that already have high percentages of seniors.

Traditional definitions of frailty center on a medically-based model that equates frailty with chronic illness, disease, and disability (Rockwood 1999, Raphael et al. 1998, Campbell 1997, Rockwood et al. 1994, Birren et al. 1991, Winograd et al. 1991, McAdam et al. 1989). Based on this medical view of frailty, health care and allied health professionals identify frail elders in hospital and rehabilitation settings to determine who is most at risk for adverse outcomes and most in need for discharge planning.

> Frailty is best regarded as a condition or syndrome which results from a multi-system reduction in the reserve capacity to the extent that a number of physiological systems are close to, or past, the threshold of symptomatic failure. (Campbell, 1997, p. 315)

By viewing frailty from the medical perspective, it further incorporates: loss of reserve, feebleness and vulnerability that often cannot be overcome. Instead, persons deemed frail are often said to be: "failing, worsening, beyond a level of help that necessitates a move toward constant care . . ." (Campbell 1997, p. 317).

Frailty--though often viewed as functional limitations--has, recently, taken on an expanded meaning (AARP 1999, Fineman 1994, Kaufman 1994, Rubinstein et al. 1992, Birrent et al. 1991, Kaufman 1986, Knight & Walker 1985) From a more holistic perspective, many researchers alter the view from "frailty as disability" to that of *functional dependence* that can be overcome through supportive environments, i.e. specially designed and modified living environments like those found in assisted living and board and care facilities and supportive services, i.e. homemaker and housekeeping services, as well as shopping, medical and care assistance.

Other--more radical--views of frailty move beyond the traditional, medically-based conceptions equating frailty with chronic illness and disability to engage a convergence of physical, social, and environmental factors that come together in individuals construct frailty (Raphael et al. 1998, Gubrium & Holstein 1997, Kaufman 1994, Gubrium 1993). This functional approach to understanding frailty is viewed in terms of the individuals' lived experiences rather than presence or absence of medical or health conditions. From this perspective, the notion of frailty is viewed as a state residing within the individual.

Definitions of Aging-in-Place

Aging-in-place is term that possesses many meanings in the gerontology literature. Among the most common definitions include: aging at [my] home, making decisions to stay in current [home] for many years, or choosing to remain at home. Gerontologists like Callahan (1993), Golant (1992), Lawton (1990), Pynoos (1990), and Morrison (1992) have stressed the dynamic nature of the term for both the individual and the housing environment. Instead of focusing solely on the environment, however, a better relationship between individual and environment must be understood and explored. In the course of understanding this complex relationship, a continual re-assessment of the person-environment relationship must take place (Bechtel 1997, Golledge & Stimson 1997, Golant 1984, Lawton, Lemke & Moos 1989). From this continual re-assessment, more effective and efficient use of social services, access to housing choices, and supportive services can be opened up. By understanding how elders interact with their environment--successfully or poorly--greater options for keeping them safe and at home can be offered.

When the United States government and HUD developed programs such as Section 202, 236, and public housing, the assumption was that tenants' needs could be addressed through basic physical plant design modifications (Pynoos 1995, Pynoos 1992, Bernstein 1982) and additions to the physical plant common area spaces such as dining rooms and rooms for a nurses, as well as the addition of assistive devices like call buttons and grab bars. Projects could also be located nearer to neighborhood amenities like shopping, transportation routes, grocery stores, and banks to facilitate mobility and ease issues of transportation. Senior housing planners, developers, and government housing officials felt that as tenants aged, they could be moved to more supportive surroundings

that offered more congruent staff attentions, design, and services. This model--known as the *constant model* as opposed to the accommodation model--was pioneered and developed by Lawton (1980) to assert that the character of the resident population can be maintained through three key mechanisms--(1) stringent medical and behavioral standards for admission, (2) competence of tenants is monitored carefully and termination of tenure is initiated as impairment becomes evident, (3) new services are not added, and incentives are offered to encourage continued and independent behavior. Though Lawton (1985a, Lawton 1985a) admits that this is not always prudent and practical.

> Of course, in actual practice, most housing is neither extreme in constancy or in accommodation. It is very probable that a middle group of less-than-complete independence is tolerated by most "independent" housing administrators, and that few housing environments accommodate totally to the changing needs of tenants (Lawton et al. 1984, p. 63)

Recent inquiries into Florida's HUD-assisted seniors demonstrates that this is not entirely the case and that often housing administrators--when exhausting all of their alternatives and patience--move residents out of independent living facilities into board and care facilities, nursing homes, or a relative's home (Golant 1999, Wilson 1998b). Alternatives that accommodate low-income, frail seniors are also difficult to find. Congregate housing offers the alternatives of meals, housekeeping assistance, and recreational/social activities is usually unaffordable. Thus, residents of HUD-assisted housing are facing limited options if they cannot age-in-place.

Frail Elderly: A Dilemma for HUD Managers

With increasing age comes an increased demand for services. Bartlestone (2000), Proeger (2000), Golant (1999), and Bernstein (1982) suggest that elders in the 75 years and older age group are three to four times more likely to require supportive services

assistance than those in the 64 to 74 year old age group. Some of the most common indicators of increasing dependence, according to Bernstein (1982) are:

1. Tenant has accidents that may be dangerous to him/herself and to the safety of other tenants.
2. Tenant is forgetful; not thinking too clearly, and sometimes wanders aimlessly and gets lost.
3. Tenant often stumbles or falls down.
4. Tenant is having problems with cooking, cleaning, and taking care of daily necessities.
5. Tenant seems to have psychological problems such as being depressed or anxious or being emotionally unstable.

Interestingly, though not surprisingly, many managers indicate that facilities that are able to bring services on-site are better able to accommodate residents in all facets of their life and allow them to age-in-place.

Since the early 1980s, gerontologists and elder housing researchers have focused much attention on the managers of senior residential facilities and the factors that influence when residents must move to more supportive housing environments (Golant 1999; Merrill & Hunt 1990; Pastalan 1990; Barker, Mitteness & Wood 1988; Ryther 1987; Bernstein 1982). With increasing numbers of tenants in the 75 years and over age group entering HUD facilities, including public housing--and the impending increased numbers in the near future--housing managers must make daily assessments about the capability of the residential setting to accommodate the abilities of the older and more frail tenants. Over the long-term these decisions will influence the conditions under which future elders are admitted to facilities and the length of time they can stay. The research of the last decade has demonstrated considerable interest (Federal Interagency Forum on Aging Related Statistics 2000, Golant 1999, AARP 1998, Polivka et al. 1996, Lane 1995, Callahan 1993, Barker et al. 1988, Lawton et al. 1985, Bernstein 1982,

Malozemoff et al. 1978) hoping to maximize the likelihood of aging-in-place, while better understanding and developing supportive services to minimize costs and maximize quality of life (Griffith et al. 1996, Holland et al. 1995, Fischer & Frank 1994, Callahan 1993, Feder et al. 1992, Callahan & Lanspery 1991, Clapham & Smith 1990, Blandford et al., 1989, Avant & Dressel 1980, Harel & Harel 1978, Bennet et al. nd).

Managers of these facilities recognize that not all health problems place their elder residents at risk of having to relocate. Some housing managers have responded to the needs of vulnerable older tenants through expansion of their "bricks and mortar" roles to include the delivery of both formal and informal support (Golant 1999, Wilson 1998b, Brice & Corey 1991, Barker et al. 1988, Heumann 1988, Lawton et al. 1985). Even minimal intervention--assistance in the forms of transportation, housekeeping, or personal care services) becomes critical in enabling residents to maintain themselves in subsidized housing.

> Managers have only recently begun to engage in these tenant service-related role, and not all have done so. Even among those subsidized housing managers involved in tenant problem-solving activities, there is great variability in the nature and extent of their involvement. (Brice & Corey, 1991, p. 487)

Unfortunately, in many cases, other needs, lack of on-site support or lack of knowledge about local services work against the elder resident to eventually force a tenant relocation (Brice & Corey 1991).

Typically, many managers are most concerned about those conditions that are most likely to threaten the older person's ability to take care of either their apartment or their everyday personal needs. In addition to supportive functions like grocery shopping, lifting, running errands and basic housekeeping, managers are concerned about age-related health issues like vision impairment, hypertension, and heart conditions.

Combined with other health problems like stroke, alcohol abuse, and depression (Golant 1999, Merrill & Hunt 1990, Barker et al. 1988, Bernstein 1982), the complications from these conditions lead managers to believe that multiple functional impairments will necessitate 24-hour care. Many facility manages consider "heavy care demand to be inconsistent with independent living" (Golant 1999, Barker et al. 1988, Bernstein 1982).

Linking Housing With Services to Encourage Aging-in-Place

For home and community-based services to be effective in the lives of needy seniors, services must be cost-effective, convenient, easily accessible, and provide the highest level of assistance in the least restrictive environment. Residents of subsidized housing are often perceived to be relatively well taken care of--their housing is often better than poor elders in the community at-large, and they are perceived to benefit from the nearness of neighbors and housing staff.

The Need Will Only Increase

Currently seniors are demanding more health care and supportive services than ever before--partly due to the sheer size of the population and partly due to a longer lifespan (Golant 1999, Feder et al. 1992, Bennett et al. nd). The last decade has seen fundamental changes in the way the home healthcare industry does business concerning accessibility and service delivery. One researcher (Gonzalez 1997) suggests that there are an:

> . . . [E]xtraordinary number of mergers involving vertical and horizontal integration. The managerial response of healthcare providers to change has typically been to expand the numbers and types of services offered in an attempt to remain competitive and to better service the needs of the healthcare referral sources. (p. 313)

As a whole, this industry has attempted to keep pace with the medical needs of a population by "broadening the array of services the firms offer, so that they can service all the needs of a [segmented population pool]" (Gonzales 1997, p. 314), as well as other service needy segments of populations. Several service providers indicate that they have only recently realized the significant levels of need, and potential for significant profits as well, in government-subsidized housing. Surprisingly, however, it has been even more recently that project managers have negotiated contracts to encourage stronger relationships between provider and project. Both groups closely scrutinize the financial benefits gained through partnerships.

If supportive services cannot be found and brought into housing projects, this population segment will have a greater likelihood of being prematurely relocated to a nursing home (Golant 1999).

> [In the state of Florida,] the frail elder population age 65 to 69 will increase by 37.7%, while the frail elder population age 85 and over will increase 89.6%, to 142,283 persons in 2010. This is the population group at the greatest risk of needing publicly supported long-term care services. Clearly, the need for long-term care services will continue to increase steeply over the next decade, putting extreme pressure on the state's capacity to provide an adequate level of care within the current framework of nursing home dominated care. (Reynolds-Scanlon et al. 1999, p. 37)

Together these factors generate significant attention to the need for affordable, long-term supportive services to supplement independence.

Despite the obvious costs of long-term care, continued development of supportive service networks and the creation of economies of scale and scope within those network contribute to improving seniors' lives, quality of life, and well being that restores independence to service dependent frail elders of low-income, government-subsidized housing. By putting these service networks into place, managers and residents can take

advantage of lower operating costs and a wider variety of on-site and community-based services to support aging-in-place. More importantly, however, these economies of scope and scale will improve the quality of supportive service and reduce their costs to the frail elders who depend on them.

Economies of scope and scale: home health and home-based supportive services

The home healthcare industry is currently undergoing fundamental changes concerning payment, accessibility, and service delivery. Literature has reflected an extraordinary number of mergers involving vertical and horizontal integration. The focus on comprehensive service delivery needs to be examined in the light of the economic concepts of economies of scope and scale. Economies of scope "imply that the cost of producing all outputs is strictly less than the cost of producing the same levels of output in separate--specialized--production units" (Cowing and Holtmann 1983, p. 647). On the other hand, economies of scale imply that the cost of producing one specialized output--at sufficiently large quantities--can reduce the overall cost of production of that specific unit. With increasing nature of healthcare competition and the emphasis on comprehensive service delivery, economies of scope and scale become crucial in the effort to provide efficient delivery of these services.

Home delivery of health services represents a large and rapidly growing segment of the U. S. health care market. In 1983, Medicare and Medicaid expenditures on these services exceeded $2 billion, representing a 27% increase over 1982 (Kass 1987, Hay & Mandes 1984). Approximately 4,500 home health agencies are currently certified to provide services to Medicare beneficiaries who in turn receive 70% of all home health services (Kass 1987).

There are two major studies that have addressed the issues of scale economies for home health service agencies.

The first study, Kurowski et al. (1979) find economies of scale in the delivery of home health services in cities in Pennsylvania and Massachusetts. While this study uncovered "weak economies of scale," critics of the study state this study suffers from two key problems. First, meaningful adjustments for case-mix differences were not included in the model itself. That is, no distinction was made between offering skilled nursing services versus those of a home health aide. Second, the study examines the relationship between firm size and cost per unit by looking at only four firms in each market. Such a small number of firms make it difficult to determine the causes of any differences among the costs of the firms. By examining the data from this perspective, they did not allow for variation within their class categories.

The second study, Hay and Mandes (1984), estimate a home health agency/ service provider cost function based on cost reports for 74 non-profit agencies in Connecticut for 1981. Their analysis demonstrates U-shaped average cost curves for agencies' provisions of skilled nursing visits, with substantial diseconomies of scale in the observable range. These researchers estimate that the average cost curve for firms, offering skilled nursing services, reaches its minimum at 7,159 visits--about 1,000 visits more per year than the sample representative agency. Like the first study, this one is plagued by problems. First, the researchers incorrectly choose to ignore the complexities inherent in the appropriate analysis of economies of scope and scale.

> Instead of analyzing the entire range of services, skilled nursing visits was focused on as the output measure because it is the only services that al agencies could provide, and it constitutes 45% of the business for the study agencies. (Hay and Mandes 1984, p. 113)

These authors have ignored the interactions and possible efficiencies in the provision of multiple service categories.

With an increasing emphasis on home health as a less costly care alternative, utilization of home health services has increased over the last seven years. Despite this increase, few attempts have been made to study the issues of economies of scope and scale in this industry. Given recent business trends in this industry and the increasingly competitive nature of the environment, cost and efficiency are important considerations for the resident population and managers of low-income, government-subsidized housing.

Approaches to Providing Services

While many elder advocates--both inside and outside government--offer solutions that address the needs of frail elders in government-subsidized housing, real solutions can only come at the state and local levels. Competing jurisdictional interests have made it difficult to get Congress to focus on the issue of linking housing and supportive services, particularly for the more frail elders in HUD housing (Pynoos 1992, Callahan & Lanspery 1991, Struyk et al. 1982. While many people believe that HUD housing programs are outside of the long term care system, more and more residents of these projects are becoming incapable of aging-in-place without supportive services.

Understanding how to best "support" this group of low-income elders is a key question that has been inadequately researched and addressed, particularly at the low-income level. Essentially, there is a housing system, represented by HUD, and a supportive service system, represented by the Department of Health and Human Services (HHS). Traditionally, each of these systems has operated independently of the other with little programmatic policy overlap. Locating the best and most long-term mechanism for

interdepartmental interaction between these two agencies has been a major--though unresolved--political issue.

Congress has encouraged a very basic approach to providing supportive services to seniors in this type of housing. By and large the major source of support comes from the coordination between HUD and human services organizations--like those funded through HHS.

There is substantial legislative history of congressional mandates for interagency coordination both for HUD and HHS agencies. The major congressional mandates include:

1. Section 203 of the Older American Act of 1965, as amended, required the Commissioner "advise, consult and cooperate with the head of each federal agency or department proposing or administering programs or services substantially related to the purposes of the Act. . . . (U.S. Senate 1989, pp. 7-8)

2. Section 202 (f) of the Housing Act of 1959 required that "housing and related facilities assisted therein will be in appropriate support of an d supported by, applicable state and local plans . . . providing an assured range of necessary services for individuals occupying such housing." (U. S. House of Representatives, 1991, p. 300)

3. Section 209 of the Housing and Community Development Act of 1974 required that HUD "consult with the Secretary of the HHS to insure that special projects for the elderly and handicapped . . . shall meet acceptable standards of design and shall provide quality services and management consistent with the needs of the occupants. (U. S. House of Representatives, 1991, p. 234)

4. Section 162(c) of the Housing and Community Development Act of 1987, since repealed, required "supportive services plans for all Section 202 housing describing the served populations, range of necessary services, manner in which services will be provided, and the extent of state and the extent of sate and local fund availability for services provision." (U. S. Congress, 1988, p. 101)

Nonetheless, there has agreement that interagency coordination has been unsuccessful. HUD housing has a history of complaints from housing authorities about the difficulty in accessing supportive services for the elderly. According to Golant (1999), Nachison

(1985) and others (Pynoos 1992, Callahan & Lanspery 1991, Struyk et al. 1989), there has been little evidence of a partnership in linking housing and services together. In fact, many researchers and public policy analysts have suggested that federal policy has discouraged the effective and efficient linkages between elder housing and supportive services (Pynoos 1990).

On a local level, there are a variety of reasons for difficulties getting services to residents in HUD facilities. Often many people believe that since housing projects are HUD supported, they contain supportive services. According to Nachison (1994) there are two major barriers to securing services in government subsidized housing. First, government funds are allocated on an annual basis, and not usually in multi-year contracts. By funding projects in this manner, there is a lag between initial funding, construction, and full occupancy. Over this period of time--often five or more years--funding sources and service providers have extremely lengthy periods to "survive" and choose not to support these types of development. Further, non-profit and other owners, usually local housing authorities, have been reluctant to build congregate housing for low-income elderly or market low-income housing to the frail elderly because of the apparent shortage of subsidized supportive services. This occurrence can be quite common and has been documented in the unpublished case study by Wilson (1998b) and highlighted in the discussion of former service coordinators and home health care providers at the 2000 Florida Geriatric Care Manager Association convention (Bartlestone 2000, Proeger 2000).

The second major barrier deals with how federal government funds are allocated to local jurisdiction on a formula basis. Until the early 1980s, when Section 202s became

formula based, projects that were approved for HUD insurance and those directly funded by HUD were not funded on a formula basis. This produced a major mismatch of dollars at the local level--especially between the number of HUD projects in a particular areas and the availability of services in that area.

Because of the fragmented policy making at the federal governmental level, a number of state and local governments have taken steps to subsidize supportive service programs for frail elders, pay for service coordinators, and train managers and staff (Struyk et al. 1989). In the late 1980s:

> The Robert Wood Johnson Foundation's "Supportive Services in Senior Housing Programs" provided $4.5 million to ten state housing finance agencies (HFAs) to test a market-driven, consumer-oriented approach that used coordinators as service brokers. The demonstration found that HFAs and housing sponsors were willing and able to commit funds to hire service coordinators, and that, likewise, tenants were able to pay for some services. (Feder, Scanlon & Howard 1992, p. 61)

This demonstration legitimized and encouraged HFA attention to issues that move beyond providing bare minimums in safety and financing sound housing. Furthermore HFA staff could move owners in a positive direction in five distinct ways: (1) apprising housing developments of service availability within a geographic region; (2) surveying tenants to determine the types of services needed; (3) training and assisting managers and service coordinators (SC) to ensure high standards of care and assistance; (4) recognition of supportive services costs so they may be incorporated into residential site operating budgets; (5) encouraging co-payment programs to reduce "excessive burden" on clients.

Several approaches to dealing with frail elders have proven successful at the local levels. However, these demonstration programs have not been widely adopted throughout the country. The most significant contribution to allowing elders to age-in-place has the introduction of the service coordinator program in the early 1990s. This

program provides a caseworker to assess elders and link them with desired or needed service. Two important programs that have contributed to elders remaining in their homes has been the development and continued refinement of the Section 202 supportive housing program and the Congregate Housing Services Program (CHSP). Both have sought innovative ways to delay institutionalization of elderly tenants and allow them to retain independent lifestyles. Lastly, I review of significant contributions of Florida's most successful approaches to supporting aging-in-place by Golant (1999) from CASERA Project findings.

Service Coordinator Approach

> H92-40 (HUD) defined a Service Coordinator as "the individual who does casework with the frail elderly and nonelderly disabled residents in need of support, refers them for assessment, links them with service providers in the community and monitors the provision of services." (U. S. Department of Housing and Urban Development 1992.

One of the most innovative approaches to encouraging elders to age-in-place in subsidized senior housing has been the development and implementation of the service coordinator (SC) program. The Department of Housing and Urban Development (HUD) created the service coordinator position to address frail elders' needs in this population. According to Schulman (1996) the Service Coordinator's job at its inception was a four-pronged function:

- Identification that resident need exists,
- Arranging for supportive services to cover needs,
- Monitor the quality of services,
- Reassessment of resident need. (p. 6)

Until the creation of this position, supportive services for the elderly were only available through the Area Agencies on Aging (AAoA), subsidized by the Older Americans Act of

1965, yet residents of Section 202s and Section 8 noninsured housing projects had no direct access to these services. Residents were dependent upon the site manager's initiative in finding needed supportive services, or their own potentially inefficient and haphazard efforts. The role of the Service Coordinator became a vital link between available services and residents filling a conspicuous gap that severely isolated seniors. They were to make the area's programs known to the residents, and it was understood that, while the program was available to all residents, emphasis was to be placed on the at-risk and frail. No resident was required to partake of the services offered. For example, an individual might use the Service Coordinator to obtain a housekeeper, and not allow the Coordinator to monitor the work of the housekeeper once in place.

With the recognition of the need for a more formal link between residents and supportive services offered by Area Agencies on Aging, Service Coordination for Section 202 and 202/8 federally assisted housing became widely available for the first time in 1992. In the 1980s HUD field offices allowed buildings--through their own funding mechanisms--to implement the positions. Since the early1990s, HUD headquarters has taken a leadership role by refining and funding the position of service coordinator to those projects that could document at least 25% of their resident population was "at-risk" or "frail." *At-risk* was defined as being deficient in one or two ADLs, but not three or more. *Frailty* was defined as being deficient in three or more ADLs. This definition became the baseline definition for frailty for this research project.

To incorporate a Service Coordinator into their facilities, HUD has two distinctive models. **Model 1**: the service coordinator is hired and supervised directly by the facility

manager. **Model 2**: building management contracts with an outside agency to provide on-site service coordination.

Model 1. In this model the coordinator answers to and is supervised by the building management. There are several important advantages of this model, including: the service coordinator is a management team member and is able to influence resident oriented policies (Holland, Ganz, Higgins, and Antonelli 1995). Residents and management come to realize the benefits of having a full-time, forty hour per week person coordinating services for facility residents. Not only do residents have someone working to connect residents with services, but they have the opportunity to create strong bonds between residents and service coordinator--creating strong assurances that "management" is interested in their well-being and good health. By being on-site, the service coordinator can also monitor the day-to-day status of residents and the affects of the provided services.

While there are many benefits to this model of connecting service coordinator and management, there are several weaknesses. The greatest concerns--raised by residents in the past--have been the perception of the service coordinator's allegiance to building management. Though residents have raised this concern, especially when service coordinators are newly introduced to a building, HUD's Office of Policy Development and Research (see Volume II 1996) has never found a single incident of this occurring. A second concern is the role confusion when the service coordinator must function as both client advocate and management team member. The difficulties of the "divided role" has been raised by service coordinators themselves, particularly when management wishes to move clients from the facility. In private interviews (Golant 1999, Wilson 1998a), many

service coordinators say that they always tried to put the needs of the resident client before the needs of a facility's management. Lastly, residents have the concern that the coordinator will not be able to maintain client confidentiality. Though these three items are often listed as the downfalls of an on-site service coordinator, the residents, management, and research demonstrate the positive aspects almost always overshadow the negatives of this model.

Model 2. In the second model, the building management contracts with an outside agency to provide an on-site service coordinator presence. The service coordinator is supervised and evaluated by an off-site supervisor. Often this service coordinator will travel to a variety of housing sites spending only a couple of hours each week at each facility. Some of the benefits of this contractual model include: client perception of objective advocacy; outside case consultation and peer support; and greater likelihood for confidentiality between the service coordinator and facility manager. The greatest weakness of this model is that by not being part of the management team, often the service coordinator will be left out of management meetings creating confusion in terms of policy decisions that affect residents.

Both models offer advantages and disadvantages, but HUD evaluations (1996) and research into the role of service coordinators (Wilson 1998b, Schulman 1996; Holland, Ganz, Higgins, & Antonelli 1995) all indicate that facilities with service coordinators have a greater likelihood for aging-in-place and staving off health issues that force relocation of residents.

Understanding these models of service provision creates a context for understanding exactly how the SC functions in developing and providing services.

Assessment of resident need has been handled in various ways by different SC programs. The last five to seven years have seen three models of assessment rise to prominence. The first assessment strategy utilizes the medical model to form the basis of the evaluation. The Service Coordinator elicits information from the client. The decisions as to what services are needed are those solely of the Service Coordinator. This client has little part in the assessment process other than providing baseline information. This first model has come to be called a **Needs Driven Assessment Strategy**.

The second model--the **Consumer Driven Strategy**--was developed through the Robert Wood Johnson Foundation Service Coordinator Program. In this program, there was no formal assessment, at least not like the one discussed above. Instead the SC marketed the services available, and the residents chose which services they wanted to purchase. The SC then arranged for those services. Quite innovative in its approach, the Robert Wood Johnson Foundation gave residents to option of choosing services from a "menu" of options. Critics of this model believe that residents do not always know what they need, or how best to ensure their safety.

The final model was developed from HUD's program requirements that the Service Coordinator programs emphasize services for those who are at-risk and frail. This third choice--developed in Florida by the National Council of Senior Citizens Housing Management Corporation--is an **Interactive Assessment Strategy** that involves the residents in their own assessment process by informing them of all data collected on intake, having them sign off on the data, and requiring that both SC and resident together determine need and required services. This third model--growing in popularity--has two key advantages. First, it limits SC liability because residents have significant

responsibility in the decision making process for supportive services. Second, due to the interactive nature of the assessment, residents are more comfortable using the Service Coordinator; and as a result:

> [Residents] have a greater sense of positive self-image, in that they realize their perceptions of themselves were valued . . . and [they] have a greater experience of control over their lives. (Schulman 1996, p. 8)

Though the basic function of Service Coordinators is the same, as individuals they have the responsibility to gear programs to the needs of their clients and the facility.

Congregate Housing Services Program (CHSP)

To address elder supportive needs, several efforts have been made to better integrate services into government-assisted housing (Golant 1999, Pynoos 1992). For example:

> In 1978 Congress created the Congregate Housing Services Program (CHSP) to provide service coordinators and a variety of services to older tenants in public and Section 202 housing. The program originally involved 63 sites, at which two meals a day and services such as homemaking were provided to approximately 3,000 frail elders. The launching of this demonstration proved to be controversial, because HUD did not consider payment for services its responsibility. (Pynoos & Liebig 1995, p. 200)

The Office of Management and Budget (OMB) felt the CHSP program did not provide an overall cost saving, arguing that it "did not demonstrate a saving of money that otherwise would have been spent on nursing home care and was therefore not cost effective, a finding similar to other home-care demonstrations" (Redfoot & Sloan 1991, Weissert 1988). This program--though continued--fell to cuts under the Reagan and Bush Administrations, limiting the number of participants. The second phase of the CHSP involved stricter targeting to clients, a greater tailoring of services, and the elimination of

the two meals per day requirement. Such actions highlight the "political" view of supporting frail elders through service programs.

This congregate housing concept sought to create an atmosphere that existed somewhere between the highly institutional environment of a skilled nursing home and that of independent settings like retirement communities. The result has been a discrete--though highly successful--set of services that elderly persons can take advantage of when needed to help forestall premature institutionalization.

Though the kinds of services offered by this program vary from facility to facility, all sites must offer some form of meal program. The typical CHSP package of services in addition to meals includes housekeeping, personal care assistance, home delivery services, counseling, and recreational activities. In addition to on-site services, many programs seek relationships with community providers, on a fee for service basis, to further enhance programming.

Early recommendations for improvement of the program fell along four distinct lines: greater flexibility of the meals program, greater sensitivity to architectural design issues of the building, more stable sources of funding, greater formalized training for staff and management to better deal with aging topics.

Overall the CHSP has been a positive force in supporting frail elders as they age-in-place, particularly in improving nutrition, prolonging independence, providing companionship, increasing self-worth and socialization, and reducing isolation. Additionally, the cost of the Congregate Housing Services Program has been demonstrated to be more cost-effective than alternatives forms of supportive care--particularly highly specialized institutional care--while maintaining high levels of

satisfaction among residents in the program. Unfortunately, it is a very small program and it is now operating in just over 100 housing facilities nationwide.

Section 202 Housing

Section 202 housing continues to be one of the best federal programs serving needy elders (U. S. Department of Housing and Urban Development 1999). While only a small percentage have extensive on-site services, many offer daily meal programs, laundry facilities, community rooms, recreational services, and special design features. While the "service provision" comes from the residents themselves--except for those sites offering a service coordinator--the overall physical design features create a more supportive environment than other subsidized housing facilities. This housing type offers the greatest likelihood for breaking down the barriers between long-term care and housing. Unfortunately, while many facilities contain a supportive physical plan (e.g. dining rooms, staff areas), housing sponsors must still initiate service delivery strategies with community-based providers and secure outside funding.

CASERA Project Findings: Successful Service Delivery Programs

Social problems associated with elders in need of services, including homelessness, poor medical care, housekeeping, and transportation, have spread across the nation's metropolitan areas during the late 1980s and early 1990s (Wolch 1996). In response, community-based services designed to provide relief expanded throughout these areas in a variety of forms to assist elders with accessing services in a highly fragmented market. Solutions to the service problem have proven to be as innovative as they are needed.

The innovative approaches in-place across the state of Florida origination from the panel of experts advising the CASERA Project was to "assist elder tenants in maintaining their independent living arrangements in their current apartment settings as long as it is economically, administratively, and legally possible" (Golant 1999, p. 19). Central to the suggestions listed in the report was creating connections with community-based networks of home care and service providers. Only by tapping into local resources can these types of facilities truly create aging-in-place strategies. Whether these opportunities come through residential facility networks to create economies of scope/ scale, negating locational effects through transportation services, or creating service infrastructure through community and in-home services, solutions must bring together residents, management, and community to create strong ties to keep elders in their homes. The five major service approaches engage specific areas:

Model 1: The Basic Service Coordination Model

> The core component of this model is the role of the service coordinator position in each housing facility, to coordinate the work of case managers and volunteer coordinators, and to create partnerships within the community. The function of the service coordinator is to identify residents' needs and support them to age-in-place.

Model 2: The Partnership Model

> The goal of this model is to establish interagency collaboration that results in the effective coordination of services. A key aspect of this model is the ability to identify the mutual benefits to be gained work co-working.

Model 3: The Congregate Housing and Capitation Model

> The goal of this model is to foster residents' independence through "one-stop shopping" service packages. In the most effective forms of this program, all services are offered on-site, targeting low-income frail elders at-risk who meet nursing home criteria as established under the Medicaid Waiver program.

Model 4: The Two-Tiered Assisted Living Program Model

> The goal of this program is to provide two levels of social and supportive services within the HUD or PHA housing facility--providing a continuum of care for residents as they progressed through the lifecourse.

Model 5: The Home Modification Program Model

> The goal of the Home Modification Model is to act as a catalyst for "organizations to make a long-term commitment to home modifications as a priority issue at national, state and community levels." Funding of this program is contingent on the composition and membership of the state and local coalitions to develop and improve these services.

These major approaches to overcome the barriers to service access bring together the needy elders, and providers through fiscal and administrative incentives to develop and create supportive service partnerships. Accordingly, cultivation of service models brings benefits to local housing and service providers and residents in seven key areas: (1) funding service coordinators for housing facilities--though some service models, (2) creating incentives for rent-subsidized facilities to provide aging-in-place services, (3) strengthening the link between the Department of Elder Affairs (DoEA) and local human services providers, (4) developing partnerships to expand supportive services to rent-subsidized tenants, (5) providing managers of rent-subsidized housing with necessary tools to meet the needs of less independent elders, (6) increasing the lobbying efforts of housing professionals to effect changes at the state and local levels, and (7) continuing to expand the research in supportive services for low-income elders.

Building Upon Past Research

This investigation into environmental congruence in Florida's government-subsidized housing projects attempts to broaden traditional discussions of "triggering" mechanisms that force frail elders from their homes by exploring social constructions of

frailty and aging-in-place with both residents and managers/sponsors. Instead of simply "labeling" residents as frail, this research investigates ways the two groups define, frame, and understand frailty as it relates to aging-in-place.

CHAPTER 4
CONSTRUCTING FRAILTY: HOW FRAILTY IS DEFINED

> Frailty is one of those complex terms--like independence, life satisfaction, and continuity--that trouble gerontologists with multiple slippery meanings. The *American Heritage Dictionary* defines frailty as (1) physically weak or delicate, and (2) not strong or substantial (1992, p. 720).
>
> In gerontology, frailty is usually defined in opposition to independence. (Kaufman 1994, p. 48)
>
> In their study of frailty and the perception of choice among a sample of old people who live alone, Rubinstein, Kilbride, and Nagy employ an open, qualitative definition: "having one or more health or functioning decrements that seriously affect the person's ability to carry out the expected and usual activities of daily living" (1992, p. 4)

What is Frailty?

With the three definitions listed above, and scores of others in books and journals, there is still no universally accepted definition of frailty. Everyone--literally--seems to have their own meaning--doctors, social scientists, gerontologists, the government, and the elderly themselves--but few researchers studying housing issues have taken the time to appreciate what frailty means to elders and managers in Florida's low-income, rent-subsidized housing. Specifically, few have taken the time to understand how elders, and those around them, conceptualize their own frailty in their own words. This research attempts to understand how two groups of people--low-income, frail elder residents of Florida's HUD housing and their managers--conceptualize and live with frailty in daily life. For this group of people, frailty becomes much more than deficits in ADLs and IADLs--frailty is something they live with, is defined by them, and sometimes imposed

on them. And while these residents literally and figuratively define their own frailty, they do not always understand the basis for their personal views.

Frailty, though traditionally viewed as simply functional limitations associated with health conditions, has come to be viewed much more broadly. Often elders in low-income, subsidized facilities are relocated to more supportive environments because they cannon accomplish tasks like housekeeping or shopping. These activity limitations, however, may not prove to be as important as environmental forces outside the individual in judging whether a person should stay on-site to age-in-place or be moved to a more supportive environment. Simply put, ". . . the presence of frailty may result from the presence or absence of numerous intersecting factors, many of which are external to the individual" (Raphael, Cava, Brown, et al. 1998, p. 1). If, for example, services are brought into a project, certain individually defined "frailties" may fade from the residential scene. For example:

> In Stockholm each subway stop has an elevator, and buses kneel low to the ground to facilitate access. Contrast this with the Toronto system, where subway elevators do not exist, escalators usually operate in one direction only, and virtually all street cars and buses make no allowance for those whose physical abilities may be declining. (Raphael, Cava, Brown, et al. 1998, p. 2)

Or consider the resident who relies on his wife to help him with day-to-day needs:

> If I did not have my wife to cook for me, get groceries, and pick up my medicine at the shop around the corner, I don't think I'd be able to stay here. That and some of the help we can get for [clothes] washing keep me here. I worry what might happen to me if she's not around. (Resident 53)

This reliance on outside service and assistance is nothing new, but recognizing its presence may greatly change assessments of individual needs linked with conventional frailty assessments. Thus in facilities with features that compensate for physical limitations, residents can remain in their apartment units independently for longer periods

> I'm not asking for special treatment. I want to do as much as I can, but they can't say I'm frail and can't do for myself when I can . . . with a little help. (Resident 99)

Viewing *functional dependence* from this perspective creates a powerful argument that supportive services in the right types of housing facilities can moderate the affects of a diagnosis of frailty. Furthermore, if residential sites are occupied by homogeneous elder populations, economies of scale allow greater varieties of services be offered at lower overall cost to the residents. Specific types of housing with specific types of services can--in various ways--influence conceptions of frailty.

The Literature of Frailty

Recent research conceives of frailty not simply as medical conditions exerting negative influences on an individual, but as a holistic construct reflecting an interaction of individuals with their environment. One research group from the University of Toronto suggests that: ". . . frailty as a condition resides *within* the individual rather than a situation which exists *for* an individual" (Brown, Renwick & Raphael 1998, p. 1). By engaging frailty from this perspective, this research project provides greater insight into how individuals classify, understand, and deal with their declining abilities, and how managers cope with the needs of their more needy residents. More importantly, however, by studying frailty from the perspective of residents and managers, it is possible to discern the importance and influence of supportive services as a response to the study participants' perceptions of frailty.

To understand frailty, as a social construction, rather than a biomedical one, researchers must view it from the perspective of individuals who live, work and deal with it every day. By viewing frailty from this perspective, it becomes not only a highly

individualized concept, but one with multiple common threads of reference between individuals. Focusing attention on these multiple common threads, researchers find many sources for defining frailty beyond the medical model. It becomes clear that individuals have their own definitions and managers have other definitions. The implications of the acceptance of a multiple model approach to frailty for policy modifications within the HUD housing environment and other senior housing facilities and service provisions are striking. Viewing frailty in this multiple model construct, it becomes possible to increase the awareness and importance of the individual's perspective and the role their building the context. Thus, in addition to its individual components, frailty should be considered a social construction that is specific to time and place (Raphael et al. 1998) across its multiple originating sources.

By understanding frailty in this manner, there is an increased sensitivity to just how significant people's relationship is with their environment. These interactions can serve as a model for moving towards a more *universally accepted definitions* of frailty. Instead of a singular medical model, frailty becomes viewed as a "dependence on others for activities of daily living" (Raphael et al. 1998). Raphael et al. (1998) further argue:

> These functional approaches advance our thinking from physiologically based conceptions in that frailty is viewed in terms of individual's lived experiences rather than presence or absence of a medical or health condition. But ultimately, frailty is still seen as a state residing within the individual, and consideration of social and environmental factors are limited to immediate proximal environments such as attitudes of caregivers, availability of finances, or ability to get around one's immediate home. Dependence on others for the activities of daily living is the defining features in these views. (Raphael et al. 1998, p. 1)

By looking at the nexus of the individual and the environment, greater opportunities for mitigating environmental and physiological limits can be addressed through supportive services, facility types, and community supports.

> We have things like grab bars around the toilet and in the shower, resident checks, and meal programs precisely to ensure that residents can stay here as they need more help . . . become more frail. (Manager 22)

In addition to the traditional medical model of frailty, this research has uncovered three other models that contribute to a person's conceptualization of frailty, that will be referred to as the manager model, service model, and individual model. Each of these three models focuses attention on a particular aspect of the housing type, management, and/or associated services. For example, the manager model examines the role management plays in the construction of frailty in the housing project and the minds of the residents. The service model attempts to understand how service access can change residents and managements' notions of dependence and frailty. Lastly, the individual model focuses attention on the individual conceptualizations of frailty and how they are shaped by expectations and life experiences. Together these four models address the variety of factors that low-income, rent-subsidized elders, and their managers, use to describe frailty. These models are highly influenced by building type, population and the size of the concentration of elders at the facility.

Medical Model of Frailty

Most of the traditional definitions of frailty are medically based conceptions that equate frailty with chronic illness and disability (Raphael et al. 1998; McAdam, Capitman, Yee, et al. 1989). Based on the medical model, doctors, case managers, and geriatric care managers attempt to identify frail elder patients in hospital settings, rehabilitation centers, and in their own homes to determine who is most at risk for adverse outcomes and most in need for discharge planning. Medical professionals--in a variety of capacities and from a variety of disciplines--work to evaluate seniors through

multidimensional assessments. While these assessments can be challenging for clinicians, assisting elders and their families in this manner can have a dramatic and positive impact on quality of life and well-being. The usual criteria used for judging frailty are listed below.

Medical Indicators of Frailty

Independent

- Independent in all ADLs with short-term acute illness

Frail

- Meets any one of the following criteria:
  - Cerebrovascular accident
  - Chronic and disabling illness
  - Confusion
  - Dependence in ADLs and/or IADLS
  - Depression
  - Falls
  - Impaired mobility
  - Incontinence
  - Malnutrition
  - Polypharmacy
  - Pressure sores
  - Prolonged bed rest
  - Restraints
  - Sensory impairment
  - Socioeconomic/family problems

Severely Impaired

- Severe dementia and dependent in ADLs and/or IADLs
- Terminal Illness

Table 4.1. Clinical Criteria to Identify Frailty in Elderly Patients.
Winograd et al. 1988 and Rockwood 1992, p. 903.

Though all of these conditions and diseases are commonly associated with elders and the aging process, there is no dialogue to examine how other factors from the individual's life impact the diagnosis of frailty or how they can be mitigated by changes in the residential environment of low-income housing.

To understand frailty, in its traditional form, one must view its origins in the health care system. Aging and health care have been intimately linked through *medicalization* and the medical model.

> The view that the problem of aging is primarily one of physiological decline medicalizes old age; that is the phenomenon and experience of aging are brought within the medical paradigm as individual pathology to be treated and cured. . . . By framing the problems of aging and therefore the solutions as biomedical, this view of aging ignores nonmedical issues--such as poverty, isolation, the loss of role and status--and thus effectively depoliticizes the problems of aging. (Robertson 1990, p. 43)

Health care professionals and allied providers, as well as other observers of health care delivery, have come to consider the broad spectrum of personal problems and behaviors to be viewed as diseases or medical conditions that ultimately must be "treated." As Jane [not her real name] observes, "When I can't do something [like an ADL], I'm labeled. Jane (not her real name) can't walk to the mail box, watch her" (Resident 49). Furthermore, they attempt to redefine or reinforce to the senior that this is how they should view themselves. This elder has concerns that diseases, conditions, and ailments "are stacking against her" to somehow make her a less desirable resident. She continues: "My doctors say that I am frail--walking is difficult for me now. I'm 87 [years old]; who wouldn't be having trouble?" (Resident 49). Other residents are in similar situations: "My doctors has told me that I am slowing down and won't be able to do things like I used to. I've already noticed that I can't do as much around the apartment" (Resident 101); "I'm spending more time accomplishing less. I don't drive as much because I'm starting to get afraid. I got lost last week and had to drive around. My doctor says this is to be expected" (Resident 97).

> Scholars have described how medicine has permeated many behavioral aspects of life, as social deviance, behavioral eccentricities, or moral problems and how they are transformed into medical concerns, or as ordinary life processes (especially

> birth and death) are reinterpreted as events requiring medical intervention (see Arluke & Peterson 1981; Conrad & Schneider 1980; Zola 1972). (Kaufman 1994, p. 46)

America's senior citizens--especially those in low-income subsidized housing--are particularly vulnerable to this type of medical management due to their lack of financial resources, family support, and coping abilities.

> **Resident**: I've been talking with doctors about some things--about getting old and dying. My world is closing in around me and I'm not able to do as much as I would like. I've noticed that I've started getting anxious . . . nervous . . . I don't know, but my doctor has started giving me a drug to calm me down. He told me that it would help even out my moods.
>
> . . . . . .
>
> **Resident**: The way he [doctor] is treating me, almost makes me think that my emotions aren't natural and normal. I need medication to understand my own moods and emotions. (Resident 72)

Because society has come to equate old age with illness, frailty, and disability, elders are quick to be overlooked, ignored, pre-judged and pre-diagnosed, and dismissed without having their needs addressed outside the context of a waiting room.

> **Resident's Daughter**: Though no doctor ever said it, there were fewer expectations of Mom ever getting better. After her stroke, they did not really expect her to get better and made plans to move her to a nursing home instead of trying to get her back to her home. (Resident 65's daughter)

These actions serves to reinforce a particular stereotype of old age and the traditional notions of frailty--older people are somehow less capable of taking care of themselves. This type of "care" reinforces a sense of hopelessness in the resident along with self-limiting expectations. This type of assessment of aging limits elders' possibilities of prolonged independent living with a positive outlook and quality of life.

Because of these medical interpretations, residents in low-income, government subsidized housing become limited in their own expectations of themselves and their

capacity to perform in their building and maintain independence. Furthermore, they learn that if they accept these medical "opinions," they will be forced eventually to move to a nursing home.

> **Resident**: I fell in my apartment last week and was taken to the hospital. The doctors did not ask me what happened, they only looked at me, spoke to the ambulance men . . . never did they ask me what happened. . . Now I have some woman calling me asking about what I do all day, do I need help, am I eating?
>
> **Interviewer**: What do you tell her?
>
> **Resident**: Nothin'. If I say too much, I know they'll try to put me in a home. I know they will. They keep saying that I'm feeble and I shouldn't be living alone. They say I need to move . . . closer to family . . . someplace else . . . I'm not moving into a [nursing] home. I don't need that.

Resident 13 knows she needs help, particularly with day-to-day activities like housekeeping, cooking, and grocery shopping, but she is not ready to surrender her life into the hands of someone else. "This is not my end. I still have more to do. I don't want to be someone's checklist" (Resident 13).

> **Interviewer**: What did you tell the doctors while you were in the hospital?
>
> **Resident**: They would not listen to me. I tried to tell them that I was okay . . . you know fine, but they kept asking me questions--days of the week, the president . . . I could not get them to answer my questions. Is this who I am . . . I don't think so. (Resident 13)

The medical model may serve the medical profession well as a diagnostic tool for underlying medical conditions, but is not an adequate judge of frailty. Simply having health conditions, or not being able to accomplish specific tasks grossly oversimplifies the person's own reality of frailty.

For all of its faults, the medical model is used the most and is one of the most amenable to mitigation by supportive services, because these types of assistance are simply linked to different frail conditions like ability, mobility, or health. This model is,

perhaps, the most ruthless in altering elders' perspectives because it has the authority of the "medical community" or case manager behind it, supporting a notion of frailty that inevitably communicate dependence and results in low self-esteem. A diagnosis of frailty is--according to physicians--physiological deficit, not a convergence of physical, social and environmental factors (Raphael et al. 1998).

The medical establishment approaches frailty as a signal for increasing length of hospital stay, nursing home utilization, and mortality (Rockwood 1999), but this focus does not correspond with the figures associated with nursing home utilization--less than 5% of the population nationally (Golant 1992). Geriatric care managers and case managers, similarly focus attention on these components of the multidimensional assessment attempting to provide services to community-dwelling elders with supportive services to maintain independence. Professionals from these fields argue that assessment findings must be linked to adequate and on-going treatment plans to ensure success. Without this systematic approach to providing care and services, few care plans will be successful in the long-run.

These traditional medical models continue to view frailty as a changing condition of ever-decreasing abilities (Raphael et al. 1998, Rockwood 1999, Rockwood et al. 1994). Understanding the relationships between the medical model of frailty and seniors' quality of life and functional ability, uncovered during these interviews, indicates that seniors--particularly low-income seniors--can improve their quality of life, health, and well-being, as well as their own appraisal of health by approaching frailty not as a disease state, but as a reaction to a confluence of personal and environmental factors and viewing

it this ways offers--in some cases--greater opportunities and hope that vulnerabilities can be overcome and compensated for.

Service Model of Frailty

Bringing supportive services into low-income, government-subsidized housing projects provides much more than assistance. While services are the most important component of the service model, an added benefit includes social interaction and companionship for the resident. Often this includes someone "just being there" for conversation, discussion of health services, and opportunities for the caregiver/service giver to provide some extra motivation and emotional support. This model brings together two very important aspects of services--the social and human components of this industry.

The ease and difficulty of accessing supportive services influences greatly how individuals understand their conceptualizations of frailty. For these residents, having services mitigates the concern over not being able to accomplish activities of daily living (ADLs) and day-to-day tasks. Thus, having on-site and community-based services provide a level of security and comfort. For other residents, however, lack of services and support translates into isolation and health complications.

> **Resident**: If I could just have someone come and visit me once and a while, I know that I would feel better. It gets so lonely in this apartment. I want to have someone that I could call if I needed help. (Resident 75)

Because there are no family members nearby, the services coming into the apartment not only provide help with tasks, but companionship and friendship to what otherwise might be an isolated elder that cannot do for himself.

> **Resident**: I know that as long as I have someone coming in to help me, I'll be fine. Things may get bad, but with Amie [not her real name] I know that I have someone who wants to help me. (Resident 61)

Often these residents do not get the assistance they need until a catastrophic health event occurs, usually forcing them to abandon their home for more supportive residential facilities. When services are made available--either by professionals or volunteers--most residents are often able to remain in their apartments despite health problems or disabilities. Despite the availability of services at many housing projects, residents are slow to accept assistance, despite need, suggestions, and--even--doctor's orders. Eventually, even residents seeking to deny their conditions--usually out of the crisis situation--accept the support and acknowledge the importance it plays in maintaining their independence.

> **Interviewer**: What prompted you to finally get services?
>
> **Resident**: [After breaking her arm in a fall], [manager] told me that I needed help. After several weeks of [my son] and [manager] talking to me . . . they were really nagging me [smile and laugh] . . . I got someone to come in and help. You know [smiling], it was the best thing. . . . But without the manager and my broken arm, it would have never happened. I'm glad he [the manager] took the time to care. (Resident 71)

Many residents realize they need some services, but do not have the money, skills, or knowledge to take advantage of the community services available when there is no one to guide them through the labyrinth of bureaucracy. Many times they do not know who to call and after a few attempts give up.

> **Resident:** I couldn't begin to tell what out there [services available]. All is I know is that I probably couldn't afford 'em. I know the woman down there [point down the hall] says I could get help . . . but I don't want no one in my house. She [neighbor] says that I should get someone to help with house duties.
>
> **Interviewer:** Would you like to have someone come in and help you? What would you want done?

> **Resident**: Cookin' and clothes washin' most. I haven't had a home cooked meal since my wife died nine years ago. There's nothing like her ham. . . . I know that my shirts need washing . . . they don't get done except when my son's wife comes once a month or so. They just can't get up here like they used to . . . they have their own lives . . . working and the kids. (Resident 67)

These people end up isolated--often not leaving their apartments--not knowing what to do to help themselves or knowing whom to turn to with questions, and with more negative frailty assessments.

With the availability of supportive services, on the other hand, residents can remain independent and viable members of the housing complex. Their personal assessments of frailty change accordingly. Most often this simply requires the cooperation of managers, residents, and--if possible--concerned family members to ensure that the frail resident seeks out available services of the housing facility and in the community. Rather than working in housing environments that are reactive to residents' situations of need, many of the most supportive housing environments, like Section 202s, work proactively to create and have services in place and on-site to provide assistance when they are needed. Thus, in these facilities like Section 202s, managers may paradoxically understate the presence of frail elders as defined by the medical model.

Individual Model of Frailty

Aging and frailty become juxtaposed with issues of autonomy, personal choice, and the freedom to create a good quality of life. Residents of low-income sometimes housing indicate that they feel they have little control over their lives. They complain that they are told how to live, eat, think, and care for themselves as if they were children. "We *are* adults, not pieces of meat. We do have a brain and have made it [just fine] for sixty or more years" (Resident 53). This model of frailty engages the personal

expectations of old age and frailty. These residents think to themselves, "If I can live independently, then I am *not* frail."

> Aging is conceived as a battle between the discrete and opposing forces of independence and dependence; one can remain in one's own home, relinquishing more and more roles and abilities, until a catastrophe, usually a health care crisis, makes one rely on others for the fulfillment of basic needs and eventually forces one into a nursing home. (Kaufman 1994, p. 47)

How residents conceptualize their lives--and thus their frailty--is a key factor in determining their success in any living environment. Their expectations shape the way they interact and react to situations in their residential environment, in turn shaping their success in that environment. By thinking of frailty as an interaction between individual and environment, greater understanding of how to support that person in any given environment can be better understood.

The residents and management participating in this study indicate that elders--at this stage of their lives, late sixties and older--feel they are no longer viewed as individuals, but rather a collection of bodies--in the most unfortunate of circumstances, they are labeled frail, perhaps, given pills, and sent to a nursing home when they can no longer function in the residential environment of government subsidized housing. Though not everyone ends up in a nursing home, many residents don't feel that doctors, social workers, and discharge planners, or their managers view them as individuals with specific needs and problems. This lack of individuality is one of the greatest faults with the medicalization of frailty and the aging process. What residents seem to want most is to understand how they should live at home with the bodies and minds that they have.

> **Resident**: I don't just want a doctor to "fix" me. To make me feel better . . . give me some pills to help my breathing and send me home. . . . I don't want that . . . I don't want to stay in a hospital, they don't do nuthin' but run tests and make ya feel worse. I want her [his doctor] to help me live my life . . . with this [points to his chest].

. . . . . .

> What they [doctors] won't do is tell me how to fuckin' live. They won't tell me how to do that . . . they won't help me . . . no one will fuckin' help me with that. I don't really think anyone can help me do that . . . can you? I know that eventually I will lose my house because I can't--I eat soup cause I can't cook nothing else, sandwiches, maybe--can't clean.
>
> **Interviewer**: House looks pretty good.
>
> **Resident**: I don't matter. If I can't do it, I'll loose all my shit . . . and end up in some fucking vegetable patch waiting to die with tubes up my ass and down my throat . . . waiting for some sweet angel to snatch my sorry ass up to Heaven.

. . . . . .

> **Resident**: You askin' about frailty . . . I don't know what that really means. I can't do . . . but I can do more than others. I have good days and bad days. Some days I can't do shit, other days I can do the lady next door. My doctors, neighbors, some friends, tell me I need help . . . but I can't afford none of that. Some of us around here try to help each other out, but even that ain't goin' so good now. Frailty must be a state of mind, but I don't want to go to that state. (Resident 16)

Residents subscribing to this model do not avoid supportive services, instead these services are incorporated into their individual conceptualizations of dependence, need, and frailty. These conceptualizations are further influenced by the interactions with more or less abled cohorts in the environment.

> **Resident**: If I didn't have the help of my daughter to help with day-to-day things like cleaning, or the volunteer from my church to get me to my doctors' appointment, I don't know what I'd do. Without their help, I'd probably have to move in with my daughter . . . I don't want to do that. (Resident 74)

For Resident 74, her "expectations" of aging include a strong participative role of her daughter. "My mother expects me to be there to help her. I'm probably here too much, but this is what she did for her mom" (Resident 74's daughter).

Residents were not so quick to define frailty or appraise themselves as frail, if they had expectations of what it means to grow old. "I know what I'm getting into. Both

my parents lived well into their nineties just fine and so will I" (Resident 7). This group presented evidence from the past--usually mothers, father, and other close relations--of what live, and growing old, would hold for them. "Growing old is not bad . . . its part of life" (Resident 7). Other residents had similar opinions.

> I'll be frail when I'm dead. Until then, I have too much to do. (Resident 9)
>
> I know that I can't do as much as I used to. But now, I have help . . . I can live alone . . . there is no way that I am frail. (Resident 101)
>
> I can't walk up to the drug store anymore, but my son takes care of that and groceries. I can still get along fine in my apartment. That's not frail. (Resident 105)
>
> As long as my people come in to help me, I can stay here. How can I be frail then? (Resident 25)
>
> I can see that I am becoming frail. I can't do as much around the house, get to my mail without being tired. I can see that I am slowing down, but that's to be expected. (Resident 76)

For residents in many of these housing facilities, the individual model of frailty presents an alternative to the "traditional" medical model of frailty and dealing with its consequences. With assistance elders can remain in their apartments with functional dependence, relying on others to take care of activities that they can no longer complete.

Manager Model of Frailty

HUD defines frailty as a deficiency of two or more ADLs or IADLs. This "definition" used by HUD officials to "define" frailty according to this research not only falls short of creating a comprehensive understanding of the term, but many managers consider it ". . . confusing . . . ." (Manager 3), ". . . simplistic. . . ." (Manager 36), and "Totally ridiculous . . . when you try to apply it to the lives of our residents." (Manager 17).

> If this [HUD definition] is how they classify frailty, it doesn't really make any sense to me. That's ridiculous. These people [residents] . . . many of them anyhow . . . are getting assistance with [activities of] daily living so they aren't frail according to HUD, but they still need help. That's the confusing thing, you seem to be saying they are frail or they aren't. But people may still need help even if they can do their daily activities [ADLs]. Frailty in that way will change from person to person and place to place. (Manager 17)

In light of these interviews, HUD managers and their low-income residents consider the ADL and IADL deficiencies difficult to understand and apply to their residents' lives. More than once this researcher had residents question, "What does it mean to be frail?" or "How do I know (or you know) if they are frail?" "I know that they can't do like they used to . . . but at home they can get by. A lot of them have help [that comes into the apartment to do housekeeping and clothes washing]. One of the housekeepers gives Bessie [not her real name] that little extra push that keeps her going" (Manager 47)

Attempting to understand the conceptualizations and meanings of frailty are difficult because there is no single, accepted definition. For some participants of this study, it is easier to determine what frailty is not.

> I can't tell you exactly what frailty is--not in a single word, not in a couple of words. It's more than that. It's what people can't do . . . it's not who people are. (Manager 17)

Other "definitions" by managers mirrored the broad definitions from any number of disciplines and agencies. Managers discussed frailty in terms of actions that could not be done or completed.

> Frailty means they cannot take care of themselves. Can't do anything. If tenants get that way they have to leave. (Manager 2)

> I don't know. You know I've never really thought about it. I suppose frailty is not being able to walk or get out of the apartment. It doesn't seem like a good word. I wouldn't want to be called frail. (Manager 33)

> If the resident cannot take care of himself, then he is frail. If he sits in bed all day that is frailty. (Manager 21)

> You know . . . frailty is not being able to walk, talk, get out of the apartment . . . not being able to take care yourself. But I'm talking about people that can't get out of bed . . . like people in the hospital or nursing home. If my tenants can't get out of bed because of an illness . . . that's not frail . . . that's being sick. If they need help, that what the service coordinator is here for. People who need help from the service coordinator are not frail. (Manager 6)

Some managers felt that frailty was something like an inevitable challenge.

> **Manager**: I know that frailty is something we all have to contend with. But we [as managers] have to do everything we can to fight it off.
>
> **Interviewer**: So frailty is an opponent? A competitor?
>
> **Manager**: Not like you're saying, but something we have to work against until we just can't do it any more. I try to do everything I can . . . I want to help them [residents].
>
> **Interviewer**: It must be exhausting.
>
> . . . . . .
>
> **Manager**: It's a battle. (Manager 3)

Believing that aging is something that can be held at bay or warded off creates an untenable situation for managers in HUD facilities. "Sometimes we [managers] get so caught up in our friend's [resident's] lives that we do--or try to do--everything we can. You know that's not a good thing. We can--and I say this as much for myself--only do so much as we can do" (Manager 4). Managers, while having many responsibilities, try to do so much for their resident, particularly in those facilities that are not well-supported, that they forget some life changes and challenges cannot be held back and are due to natural aging. "There's a poem that I think about when I start trying to do too much . . . I don't know his [poet's] name. Something about raging against death" (Manager 4):

> Do Not Go Gentle into that Good Night
>
> Do not go gentle into that good night,
> Old age should burn and rave at close of day;
> Rage, rage against the dying of the light.

Though wise men at their end know dark is right,
Because their words had forked no lightning they
Do not go gentle into that good night.

Good men, the last wave by, crying how bright
Their frail deeds might have danced in a green bay,
Rage, rage against the dying of the light.

Wild men who caught and sun in flight,
And learn, too late, they grieved it on its way,
Do not go gentle into that good night.

Grave men, near death, who see with blinding sight
Blind eyes could blaze like meteors and be gay,
Rage, rage against the dying of the light.

And you, my father, there on the sad height,
Curse, bless, me now with your fierce tears, I pray.
Do not go gentle into that good night.
Rage, rage against the dying of the light.
Dylan Thomas (1951)

It isn't possible to "rage against the dying of the light" without sacrificing dignity, autonomy, and humanity. But often that is what it comes down to for many managers and residents in trying to determine how to live best with the "deficiencies" that the residents have. For many managers, this is the best way to "maintain a more even keel in dealing with a resident's crisis" (Manager 35).

While managers try to help their more needy residents, they can't do it alone. In cases where managers and other facility staff are busy with "bricks and mortar" issues, those complexes with service coordinators or case managers become crucial components of a system of support to keep needy elders at home.

> Without the [service coordinator], I don't know what I'd do. She arranges everything for me--otherwise I'd probably sit my apartment and cry. (Resident 84)

Specialists like service coordinators or case managers offer housing complex managers the opportunity to "step away" from helping residents find services. In this way, the

service coordinator can work for both residents and management to ensure the best world for both groups by supporting the needs of individual frail residents and the broader concerns of the housing environment.

On-site managers in HUD facilities attempt to offer as many options as they can--working within the constraints of the facility, government regulations, and the services accessible to the local population. One manager (Manager 35) worked to keep his residents "at home" in their apartments, but admitted it could be difficult. "Frailty . . . whatever you want to call it, takes its toll on both residents and us [managers]. In Section 8s we can only do so much. The reality is that help can't always be there when they [residents] need them" (Manager 35). Other managers mirrored this sentiment stating that frailty is something we all have to live with. For some residents, physical and emotional limits force them to move out and back with family or into homes.

> We [HUD managers in general] try to offer as much as we can to support our older residents. If we know of services, we try to get them [residents] in touch. We can't create services. We can't call in services, most of these residents can't afford them [fee for service]. Most of the residents wouldn't even want them. Most of us try very hard to keep them living here, like [resident's name], but that isn't always possible. . . . (Manager 43)

Many managers interviewed for this research spend portions of their workweek trying to find and maintain relationships with community services that could be brought on-site. "In this seeming time of prosperity, not as many people are giving their time or money [to charities]" (Manager 16). Because of the lack of dollars, many churches and public service organizations are having to be very selective in the programs being funded--there is not enough money to support all the worthy programs or an area's needy people and families.

> We have to work within the guidelines of HUD and the options given to us by the local community. We can't always pick and choose . . . . We recently were cut

> from a programs that was helping fourteen residents with grocery shopping and meals.
>
> . . . . . .
>
> On the issues of frailty, we do what HUD tells us . . . if they can't take care of the apartment, they go. . . . That's all we have . . . that definition. (Manager 19)

For the at HUD agency in Washington, DC, there is no ambiguity in defining frailty. According to them, and other government organizations, frailty is simply ADL or IADL deficiencies. If residents have more than four deficiencies, they are labeled frail. But even that definition is unclear when working with residents from these types of facilities.

> [Frailty] This really depends on how we can help the residents. I've worked some places that one or two big problems and they [residents] have to go. Some places just aren't ready to deal with problems. It all depends. (Manager 7)

While there is no ambiguity with HUD's definition of frailty, many of the on-site managers try to offer flexibility in dealing with problems.

> **Manager**: At my facility, I can deal with more [residents'] problems. I've got a service coordinator, many services coming into the complex. I can deal and I can help work to keep residents at home. But I also know places . . . in fact less than 30 minutes down the road . . . that have frail seniors and its much tougher to keep them at home. For low-income renters, 202s versus other like Sec 8s or PHAs makes all the difference. . . . (Manager 27)

Understanding the term frailty as simply a label or definition, however, overlooks the interacting factors and range of environmental elements that make frailty so complex and contribute to its difficult comprehension and nature. By attempting to reduce these complexities to relatively simple definitions--like those the federal HUD administrators use--obfuscates the components that need the closest scrutiny.

Summary of Frailty Models

Attempting to understand the conceptualization of frailty in Florida's low-income, subsidized housing has revealed a unique psychological system among residents and

management. I believe that together these two actors jointly create and share the definition of frailty, that for each has highly personal origins. Part of the difficulty in trying to uncover these definitions--and perhaps why some agencies are so quick to "define" them as simple ADL or IADL deficiencies--is due to the competing discourses that exist in the residential environment of the low-income, subsidized housing. The case studies in this chapter, and those in the next chapter on aging-in-place, demonstrate the complexities of the unique components as the two actors shape and re-shape definitions through discourse.

The housing complex, its staff, and population are important contributors to constructing the meaning frailty. Particularly in the more supportive environments of Section 202s, even small changes in their apartment complexes can have beneficial effects on these interpretations. In facilities with few design modifications and little supportive service assistance; on the other hand, residents are more likely to feel isolated and ill at-ease over their residential living environment. For example, before elders needed assistance climbing stairs, the ramp was un-used for accessing raise entryways of buildings. Before concern over falling and not being able to get up, there was no reason to have a remote alarm that could be worn around the neck in the event of an emergency. As residents become more needy and require--or desire--more assurance and support, ramps become used with walkers, the peace of mind of knowing that someone is within a quick phone call or panic alarm, people do--out of concern--check up on residents.

> After I broke my ankle, I realized the why those handles were in my shower and around the commode. (Resident 4)

Thus, to borrow a phrase from Sharon R. Kaufman of the University of California, San Francisco, *frailty becomes more fully articulated in dialogues concerning*

health, supportive service utilization, activities of daily living (1994, p. 50) as the two groups work in their environments. For this research, frailty has four major constructive models--medical, manager, individual, and service. These four models comprise the dynamic processes that "construct" frailty in Florida's low-income, subsidized housing for both managers and residents.

By viewing frailty in this manner, frailty becomes a dynamic process that is the sum of much more than a medical diagnosis. As such, more possible solutions are able to affect change in a "frail" individual's life.

> In our view, which is our own social construction, frailty is seen as a condition of lived experience reflecting the intersection of unique individual factors and proximal and distal environmental factors. (Raphael, Cava, Brown, et al. 1998, p. 2)

Defining frailty in this way highlights the importance of human/environmental transaction--allowing the intersection of the social, organizational, and the built aspects of the environment; roles of culture and its related social and political systems and institutions; the evolution of technology over time; and intervening psychological processes (Golledge & Stimson 1997).

Frailty: Case Studies

The five brief case studies and the excerpted sections of the interviews now examined in this chapter engage the questions pertinent to exploring frailty with the two groups of actors. Do they have a meaning for frailty? What actions or behaviors contribute to a label of frailty? What problems are they trying to solve or eliminate? What types of services can help diminish or eliminate frailty? Are there cultural assumptions about the resident or manager that contribute to greater or diminished

understanding of frailty? The following "stories" illustrate issues confronted by residents and management in Florida's subsidized, low-income housing.

The five case studies presented here are from two distinct categories of the 48 sites interviewed--the low/small populations and high/large populations. These two categories were chosen to illustrate the extreme cases that are reflected between population homogeneous Section 202 housing facilities and the population heterogeneous non-Section 202 housing types. The importance of these illustrates resides in the fact that housing type and the supportive services associated with those housing types play an important role in influencing management's philosophy of aging-in-place and frailty. Case studies 1 and 2 take place the Section 202 housing interviews, illustrating the roles that supportive services, highly specialized physical modifications, and specialized staffing play in the conceptualization of frailty. These two case studies represent ideal or optimal situations for supporting frail elders. The other three case studies illustrate housing types and population concentrations and numbers that are more likely to contribute to frailty due to their heterogeneous populations, non-supportive design features, and--often--inexperienced staff and management. The complete illustration of the site selection criteria is displayed in Table 2.3.

The five case studies selected illustrate the operation of the four models of frailty in different building contexts. Because most elders live in age heterogeneous facilities--Section 221s, Section 8s, and Section 236s--rather than age-homogeneous buildings like Section 202s, these interviews were included to document "average" situations for elders in Florida's rent-subsidized communities. A disproportionate number of facilities are

going to have populations with few design modifications and little supportive service assistance.

Each case study demonstrates the application of the four models of frailty described in this chapter--medical model, manager model, individual model, and service model. While the case studies do not mutually exclude the other frailty meanings, they do tend to collect around one or two defining a particular model of frailty. Case studies are categorized into specific categories based on the most significant subjects exhibited in the interviews. These four models form the basis for managers and residents to construct frailty through their life experiences.

Case Study 1: Service Model of Frailty

Resident 34, an 83-year-old white male, lives in a central Florida Section 202 housing facility that has both a high concentration and large population of elders. He lives alone, has no family nearby to visit him, and prefers not to see his daughter. She has been insisting that he move closer to her in Ohio. Resident 34 admits that things are not as good as they could be--his health is deteriorating after a second stroke and he highlighted six other "minor" medical problems including psoriasis, skin cancer, and an enlarging prostate, among others. His living room is full of old mail, books, newspapers, and a small television sits on the floor next to his chair. In the corner of the room are a walker and a cane. The apartment--relatively clean--has a slight smell of urine, but his clothes and furniture are unstained. He appears to have good hygiene with his teeth soaking in a glass on the end table nearest his chair. Resident 34 eats most of his meals in the dining room, but has received meals delivered at home by a local provider. Recent

health declines have raised concerns among the resident, on-site manager, and service coordinator that more services might be needed.

> **Interviewer**: Do like living at [name of facility]?
>
> **Resident**: Oh, yeah. This is a good place. I know people that may not think so, but it is. [Manager] tries real hard to take care of us. I don't always think it's what best, but it ain't my place.
>
> **Interviewer**: Regarding [facility], what do you like best?
>
> **Resident**: Lots of things to do, places to visit. You can always find someone to play cards with at the [on-site] game room. Sundays they have church, but I don't go. I can get a meal if I want, but I like to go down the street. Between you and me, the food tastes better at [restaurant]. Mostly I go to the game room. I like to play cards, you know--poker--just for pennies. You know. And we can go on trips if we want . . . the bus takes us around. You can't go anywhere, but shopping, lunch--once a week--sometimes they have places for us to go. Sometimes me and [resident's name] and [resident's name]--oh, maybe I shouldn't say their names--you won't use their real names will you?
>
> **Interviewer**: No, I won't use their names. You were talking about the bus. . . .
>
> **Resident**: Like I said, we would go to [sandwich shop], not just us, but everyone that wants to. If you are here on Thursday, you can go with us. . . . That's probably the best thing about this place . . . at least for people like me that can't drive--you'd be surprised, there's a lot of us.
>
> . . . . . .
>
> I used to live across town at [residential facility] and it wasn't like this. We didn't have no transportation. You could get help with things, but they didn't have [a service coordinator], no one like her. Some people didn't ever really get out there. For those people we would try and help, but some people don't want help . . . I can understand that more now.

Resident 34 continues to talk about his facility and compares it to another one he used to live in--one that is not a Section 202. For him the most important aspect of his residential environment is the transportation, it "gets me outta here when I need someplace else to go" (Resident 34). He points out some of the other special design features--the grab bars in the shower and around the toilet, and the emergency pull cord in the doorway between the bedroom and living room. "My other place didn't have

those. My daughter put bars around the john for me at the other place, but that was it." Resident 34 didn't need much help in his other apartment and only decided to move to this facility because the bus route to visit his friends at this facility was changed. "It took two goddamn years to get into this place, do you believe it? I never would have thought."

Throughout the conversation, Resident 34 talks about changes of what he *could* do at his other apartment, but can no longer do at this one. "I remember that I used to clean my apartment, do my own wash, wash my car, and still have enough vim to go out dancing. Believe it, I used to go out dancing." He talks about the woman that comes in twice a week to help him. "Thank God for her. Before she started coming, this place was going to hell." The services that did not seem that important initially, suddenly became more so as he realized housekeeping and other chores were not getting done. "Slowly, the clutter just started piling up. I don't know where it all came from, but I just couldn't get it all done during the week. I couldn't get wash down to the laundry room and keep the house clean."

> After my stroke, my doctors tells me that I am not going to be like I was . . . that things are going to change . . . and that I might need more help. [resident continues talking about aid and assistance that he receives from local sources.] Some days I need help getting around, but not usually . . . It all depends. Usually, I can take care of myself. I get one meal at home [resident makes it himself] usually a sandwich or cereal. I can get one meal here [pointing downstairs through the floor] that one [is] hot. Usually it's pretty good. They don't season the food the way I like, but its hot.

Over the last two years, the service coordinator began checking on Resident 34 and suggested that someone help him. With very minimal expenses each month, he could afford to have help twice a week. Now, more work around the apartment gets done.

Mrs. [service coordinator] makes sure that I have the things I need. I've got someone that comes in helps me out with things . . . my clothes get washed, some cleaning, you know the things.

. . . . . .

Interviewer: Do you believe those services make a difference in your life? Are they a help to you?

Resident: I like the lady that comes in now. She understands the system. I don't want her cleaning these things [points to the mail, books and magazines]. I might need these, so I keep them here.

Resident 34 had strong feelings about the issue of frailty, what it means, and how it is manifest in this housing facility and in himself. Though he doesn't readily identify with issues of frailty, he realizes that his weekly assistance plays an important role in his independence.

Resident: I try not to tolerate feeblety [sic]. Even if I can't do, I try to help my friends to stay up. I know that if I need to I can get it [general reference to anything that really needs to get done] taken care of. I have to believe that.

Interviewer: Why is that so important?

Resident: I need to now that I can get stuff done. You're young, but you won't always be. It's important to know that you can get things done on your own. . . . It more than pride . . . it's value in yourself. Knowing you can still do for yourself.

. . . . . .

Interviewer: Earlier you said something about feebelty [sic]--is that the same as frailty? Does that word mean anything to you?

Resident: You asked . . . bout feeblety [sic]. Feeblety [sic] is not getting around . . . not being able to take care of yourself. I don't really cook for myself. I don't clean, my wife used to do that. I don't drive anymore, but there is a bus that get me around. I have pretty much everything I need. Oh sure I'd still like to fish . . . there's no bus that takes me to do that [resident smiles] ya know what I mean . . . but I have other things to do. I know some people who hate this place, but its better than some. [Resident elaborates on the conditions at other housing facilities.] They take pretty good care of us here. If I wanted some one in here to clean, I could get that.

. . . . . .

> **Resident**: But I'm not feeble . . . or frail . . . or whatever you call it. I may not always be able to do for myself, but with help I'm fine. It's like when my daughter wants me to move to Ohio, [service coordinator] talks to her and say that I am fine. When I become feeble, then I will move. But I'm not telling that to my daughter. I'm planning to stay here a while longer [resident smiles].

For Resident 34 interpreting frailty means keeping and achieving his daily goals and activities on his own. His primary goals are to understand--from his doctors, the manager, the service coordinator, and his daughter--how to best create a quality life and remain in his home. He explicitly states, "feeblety [sic] (frailty) . . . is not being able to take care of yourself" but as long as some supportive service fills that void, Resident 34 is able to meet his vision as an independent person. Whether this resident meets his goals through his own actions or those of services supplied by the service coordinator, makes no difference. In his mind, he is independent as long as the important activities of daily living are completed.

> **Resident**: As long as it [any necessary event] gets done, I don't care whether I do it or the cleaning lady does it, or the person who gets groceries for me. I am my own man . . . on my own or with their help.
>
> . . . . . .
>
> **Resident**: To me, the important thing is that I have the help I need to get the work done. That's all I want . . . that's all I need. That's what's for me.

Resident 34's manager states, "Joe (not his real name) is a success story here because he was not doing well several years ago. That has all turned around. Some help--housekeeping and errands--and he can stay in his apartment barring any major health problems or another stroke. Even then, we re-evaluate and see what can be done" (Manager 37).

Discussion

Many components come together in Resident 34's situation to define frailty. Of primary importance is his access to supportive services in the form of housekeeping and other household chores, though he relies on other services as well. Though he views his frailty from the perspective of the service model, other factors like housing type, elder concentration, and elder population are also large components. Because he defines his frailty in terms of service access, he is fortunate to live in a Section 202 building that is not only the most supportive frail, elder subsidized housing type; but, due to high concentration and large population of elders, Resident 34 is better able to access those services because of the presence of strong supportive service networks. His building takes advantage of both on-site and community based service support taking advantage of economies of scope and scale to provide a variety of services at low-cost.

This resident becomes an ideal situation for frail, low-income elders in that he is in a highly supportive building, has low-cost (or financially reasonable) access to services, and--as for added support--the assistance of a service coordinator to offer assistance in crucial periods of need. All of these factors come together to allow this resident to have a less negative opinion of his frailty.

Case Study 2: Individual Model of Frailty

Resident 73, a 79 year old black female, lives in a panhandle Section 202 housing facility that has low concentrations of elders with an overall low population number. She lives with her husband (Resident 72, 81 years of age). The couple has family nearby--within an hour--and they visit regularly, usually once or twice a month. Though the wife has angina and high blood pressure, she maintains an "active" lifestyle making sure she

gets "out and about" in the complex with an early morning walk around the complex. The husband has diabetes, failing eyesight, and an amputated left leg, spending much of the day indoors, though he sits on the "porch" while his wife walks the complex. Both residents say they are in fair-to-good health and cite the nurse practitioner visits as the primary reason. Both have been in-and-out of the hospital in the past year with both minor ailments and major health conditions. Between the two people, they take 13 prescriptions a month, a major monthly expense. The one-bedroom apartment is clean and neat. A pan from breakfast sits soaking in the kitchen sink from breakfast.

> [The couple is sitting together at their dining table drinking coffee.]
>
> **Interviewer**: You have a nice apartment, how long have you lived here?
>
> **Resident 72 (F)**: We've been here nine years. . . . You wouldn't think this would be a big apartment, but you try and clean it somedays. We have someone that comes in weekly to help with laundry, change the bed sheets, clean our bathroom and sometimes vacuum. Usually, I can do that myself, but lately my heart gives me fits. My doctors kept telling me that this would get worse [pointing to her chest], but not like this. Some days I can hardly get out of bed . . . some days I can make it down to the main room to visit with friends.
>
> **Resident 73 (M)**: She does well taking care of me. I never though life would turn out like this. I didn't realize 20 to 30 years ago that diabetes would do all this to me. I never thought I'd be blind. We've started trying to change our diets and eat better. [The nurse practitioner] that stops here every other Wednesday has given us information on healthy eating. We haven't had to cut back too much on red meat [laughs], we can't afford that much of it anyway.

The couple begins talking about the changes in their lifestyle--both positive and negative--that have resulted from the conversations with the health care provider visits, changes suggested by their doctors, and information on exercise and nutritional health provided by the HUD facility. Resident 72 (F) states, "We're the healthiest we've ever been . . . probably." Additional motivation for their healthier lifestyle comes from the volunteer services that shop for the couple. The church volunteer that does the shopping

happens to be a physical therapist. "She tells us exercises that we can do to strengthen our muscles and stay limber" (Resident 72 (F)). Both residents demonstrate different stretches and exercises they do to keep fit and healthy. "We've both learned a lot," says the husband.

> **Resident 72 (F)**: We're lucky to be here. Not only do we have the nurse that comes to visit us, but also transportation and meals down in the dining room. We also have a nice park across the street, but we haven't gotten down there lately . . . Tom's [not his real name] wheel chair got stolen.
>
> **Resident 73 (M)**: This neighborhood is a changin'. My chair would have never been stolen years a back, now things are a changing. There's that criminal type around sometimes.

When asked specifically about issues of frailty, both residents were slow to respond. "I know that frailty means weak, not able to take care of yourself." (Resident 72). Neither resident wanted to say something in front of the other. Each resident considered him- or herself to be partially defined in the other. Both realized that the interviewer knew this, but were hoping to ignore the question.

> **Interviewer**: I know this is hard, but think about it for a minute. Would it be better to speak with each of you separately? Would that be better?
>
> **Resident 72 (F)**: This is hard. Maybe it might be better . . .
>
> **Resident 73 (M)**: [Interrupting] It's okay. It's not like he's blind or stupid . . . he knows what's goin' on. I know that she does a lot for me . . . probably so much that if I were alone I'd need to have some one help me or things wouldn't get done. She does a lot for me.
>
> **Resident 72 (F)**: [Interrupting] Young man, this is what a marriage is. This right here [pointing to herself and her husband]. We work to help each other. He does what he can and I do the rest. You wouldn't know it to look at him, but he did a lot for me years ago. He took care of me. Now, I guess it's my turn. This is love . . . this is what loving couples do for each other. I don't do it 'cause I have to; I want to.

Each resident wanted to protect the dignity of the other. It was obvious that Ellen [not her real name] did most of the work around the house because she was in better shape.

But she wanted to protect her husband's concept of himself as a man. "He's the man of the house. I do what he says." Like the resident discussed in the first case study, these residents identify with personal accomplishment of activities that comprise daily life; but these two residents function as one individual. They have a symbiotic lifestyle that, together, meets their needs. Attempting to understand better their relationship, the conceptualization of frailty becomes not an individual conceptualization, but a mutual one between *two* individuals.

Interviewer: So frailty means weak? Are all frail people weak?

Resident 73 (M): I think my wife doesn't want to answer because it would hurt me. Frailty is more than weakness . . . maybe it's fear or worry. I don't think I would call myself frail, but I'm not . . . I don't know.

Resident 72 (F): [Interrupting] Like you said, I do take care of you. Is that frailty? [To the interviewer] Do you think we are frail?

Interviewer: That's not for me to say. What would make you think you are . . . or are not frail? Do you think you're something else?

Resident 72 (F): He definitely needs help, but just because he can't do it, I don't think means he's frail. My doctor says that I'm becoming frail. That sounds like an old person. You know I really don't think of myself as old. You know [smiling] young at heart.

Resident 73 (M): I think that I would consider myself older . . . not old. I don't get around after having my leg taken off. I think I feel better about myself, but there is too much that I can't do. Too much that you [wife, Resident 72) has to do.

Interviewer: Is frailty a part of aging?

Resident 72 (F): No. I don't believe that. You can be old and not be frail.

Resident 73 (M): [Interrupting] And you can be young and be frail. Think of that kid that lives here. He's retarded.

Interviewer: Is that frailty? Why is he frail?

Resident 72 (F): Don't look at me, you answered.

Resident 73 (M): He has to have someone help him. I think frailty is being out of control.

Resident 72 (F): Frailty is being out of control. Not knowing who you are and what you're doing. Being at some else's mercy.

Resident 73 (M): Not being yourself.

Interviewer: That brings me back to you [Resident 73]. Are you being yourself? Are you at your wife's mercy? Are you frail?

Resident 73 (M): [After hesitation] I guess not. I can do what I need to. More than the retarded kid.

Interviewer: Do you think your husband is frail?

Resident 72 (F): No, he isn't. He does what he needs to do and what I need him to do. We are a couple. We take care of each other. We have help come in. We learn about diets and exercise and stretch. We are learning more and more . . . how can that be frail?

Discussion

As long as this couple can care for each other and with the help of their housekeeper maintain the apartment, they will continue to view themselves as viable tenants in the complex. This couple views their frailty from the perspective of the individual model, much of how they define frailty comes from how they view themselves and each other. This couple takes on a very positive notion of aging and conceptualization of frailty, partially because of the high levels of support they receive in their Section 202 housing project. The services like a nurse practitioner and housekeeping assistance serve to reinforce the positive notions they have toward their own short-comings. The high levels of satisfaction, strong positive notions of aging, and high success with difficult activities all demonstrate the supportive aspects of the Section 202 housing type and its creation of an appropriate aging-in-place environment.

Case Study 3: Service Model of Frailty

Resident 80, a 69 year old black female, lives in a south central Florida Section 8 noninsured housing facility with low concentration and small population of elders. She is in the final stages of emphysema and is on oxygen much of the day. When able, she likes to sit in the courtyard and watch residents, but the summer heat has forced her to remain inside much of the day. Her son brings most of her meals and her daughter-in-law does housekeeping and laundry at least twice a month. Because of her physical condition, and not having anyone to regularly assist with bathing and other personal hygiene activities, Resident 80 has not had a bath in more than a week. She is comfortable, but has concerns about her future in her home, worries about her son and daughter, and about meeting her needs in day-to-day activities.

Interviewer: How long have you lived at [facility's name]?

Resident: I've been here 3 years and God willing, I'll be here three more. I moved here after the man I'd been living with--for twelve years--threw me out. The shit. I don't like this place much. I'm not near my family. They are about 45 minutes away, but I couldn't get in to a place closer to them.

One of the biggest complaints about the complex is "too many children running and yelling around here. You'd think a building was on fire." Because the building is not age-segregated, she is very concerned that the children are running past her door in the early evening making noise and knock on her door. "I can't sleep. Yelling, playing music. Their mammas let them play music at all hours with those nasty words."

Resident: There are too many kids around here, screaming and yelling. I like to sit in the courtyard . . . and it used to be quiet, but a bunch of families have moved in the last year or so. Just too many kids. I've tried to make friends with their mammas, but they're too busy. I used to go down to the office and talk with [manager], but I'm too far back [in the complex] to be able to make it up there [with my tank of oxygen].

Resident 80 would prefer to be in a facility that had more people her own age. She misses the companionship of people her own age--people with similar interests and problems. "I need my people [those of a similar age] around me." Her closest senior friend is two buildings away (about 150 yards). "Oh I wish I could get over to see Tracy [not her real name] like I did. We had such fun. I miss having people my own age around." Because the complex is not designed to support elders, very few building modifications are present.

> **Resident**: I won't go trying to walk over there, even if I could because there are no roads [pathways]. I can't drag my tank [of oxygen] through the mud. You should just try it. It may have wheels, but that make a damn bit of difference.

The overall layout of the complex makes it difficult for people with disabilities to move throughout the complex--sidewalks are not level, having buckled from tree roots, pathways are poorly lit at night, and buildings are raised three steps above the sidewalk.

> **Interviewer**: Do you get help from anyone other than your family?
>
> **Resident**: Lord, don't I wish [reaches out to touch my arm]. Oh I wish I did, but with my other expenses I can't. For a while my church was helping me a bit . . . with money, clothes, some food, but that all dried up. Sometimes my minister comes to visit.

Resident 80 doesn't have enough monthly income to afford housekeeping or assistance programs. She has been trying to get on the "meals on wheels" route for two months, but funding has prevented that from happening. Because of her failing health she is unable to take care of her apartment, get groceries, or cook for herself. The complex manager had to make an emergency visit to her apartment one night after she fell out of the bed and couldn't get up. After crawling on the floor all night, she reached the phone calling the front office for help. "I [manager] worry about [Resident 80]. She is one of those people

who is going to try to stick it out on her own when she really needs help. This just isn't the place" (Manager 14).

> **Resident**: My son keeps telling me that I should move in with him, that's just cause [manager] here say she will have to have me move out if my apartment doesn't stay clean. About a month ago, she was in my apartment and had a holy fit. She called my son and told him that they had to "check" on me . . . you know keep their eye on me like I'm some child. Well, I not having none of that. I'm scared though because what will happen to me? Where will I go? [Resident starts to cry.] What can I do? I don't have money. I don't want to go to a nursing home. Oh, God . . . what will I do?

Less than a month later, Resident 80 left her subsidized housing complex to move in with her son and daughter-in-law. According to the manager, she was not taking care of herself and the apartment. "She posed a risk to herself and the other tenants. She started smoking again, and to be honest thought she might blow herself up with that tank of oxygen."

> **Manager**: I have about 50 seniors out of about 350 residents. I just can't keep track of them--believe me I try. Most of them are independent, but like [Resident 80] if they can't take care of themselves, they have to go. There is too much that can happen and--frankly--we aren't equipped to deal with it. When they get to be like [Resident 80] its better that they go someplace they can be taken care of.
>
> . . . . . .
>
> **Manager**: There's another one here who--I think--has Alzheimers. She has set her kitchen on fire, left pans on her stove, gotten lost in the complex here. I've tried talking to her kids, but they don't want anything to do with. I'm trying to involve [social services] but that's the most I can do. Right now, I try and check on her almost every day. I don't know all of what's out there, but there has to be better places than this to help old people. I love them, but I've got to do what's best for them.

Discussion

Unfortunately, the problems faced by this resident are not uncommon, particularly for the housing type and population concentration. Very few seniors in Section 8 housing--or other types of non age-segregated senior housing--have access to the

varieties of services needed to assist seniors to age-in-place. The lack of physical modifications to the complex as well as wear and tear on the sidewalks and pathways, and the lack of lighting--create a dangerous environment for frail elders like Resident 80. Additionally, Resident 80's view of frailty was conceptualized around access to and the need of services. Because she could not access needed services from her Section 8 apartment, she eventually was forced to move in with her son and daughter-in-law for care.

Case Study 4: Manager Model of Frailty

Resident 17, a 71year old black male, lives in north central Florida Section 8 noninsured housing facility with a small number of seniors, but who dominate the tenant project. He is a diabetic who, according to management, does not take his insulin regularly and often binge drinks. Within the past month he has been to the hospital three times and arrested once for public intoxication. According to the manager, in the past, the police would hold him overnight to let him sober up, but never charge him. He lives alone, keeps to himself, and doesn't like management "interfering" in his life. He was reluctant to grant an interview, but decided to do so after the interviewer bought him a hamburger, french fries, and a soda.

> **Resident**: This food is good. You've got til I'm done with the burger. What do you want to know?
>
> **Interviewer**: How long have you lived here? Do you like it?
>
> **Resident**: I've been here [gulping down hamburger and french fries] 6 years. I hate it here . . . ain't got no one or nothing. My woman died of AIDS two years ago. I've probably got it, but it don't matter. [Stuffs more fries into his mouth]. This place ain't no better than any of the other ones . . . been in places from Miami to Jacksonville and a couple in between. It ain't nuthin' but a thang.

Interviewer: The manager said you've been in the hospital a lot recently because you don't manage your diabetes.

Resident: Yeah . . . don't take care of myself. I should, but it don't fuckin' matter. I'm ready to move on.

Interviewer: Move on down the road?

Resident: Fuck no . . . move on [resident places his palms together and then flaps them like wings]. You know die.

Interviewer: Why?

Resident: I'm old. I've done it all . . . or as much as I'm gonna do. Nobody gives a shit anyway. Look around . . . do you fuckin' think anyone here gives a shit? Naw [resident drinks some soda and places a handful of fries in his mouth].

Interviewer: Would it make a difference if there were someone checking on you? Someone to help you?

Resident: Who's gonna help me? Let me show you something . . . [resident open the door to his apartment] . . . does it look like someone is helping me? The air [air conditioning] don't work right . . . I don't think it ever has . . . smell that . . . stinks, don't it.

Interviewer: Are there services that could make a difference in your life?

Resident: Not any more. I don't want nothing. I'm just waiting to die. Look around. Do you see anything worth living for? I ain't got no one. Maybe a couple of years ago it would have made a difference but not now.

Though not realizing it, this elder "painted a vivid picture" of his conceptualization of frailty. Most importantly, he believes that no one cares about him, his well-being, or his health. Frailty--for this person--is not defined within himself, from the perspective of services, or from medical personnel--rather, he takes much of his definition of frailty from the "definitions" placed upon him by the manager. That is to say, that he doesn't see himself as frail, instead people from the outside, like the manager, believe him to be frail. This resident has no hope and no real future.

Interviewer: What does frailty mean to you?

Resident: Frailty is getting old. Frailty is having no one give a fucking shit about you . . . what happens to you. Whether you're dead or not. You see these fingers [holds up arthritic hand], this is frailty.

Interviewer: Are old age and frailty the same?

Resident: Getting old is getting frail. There's nothing you can do. Not a fucking thing.

Interviewer: Earlier, you said services . . . help . . . might have made a difference. What did you mean? How would it have changed your life?

Resident: I don't know that it would have [chews more french fries and takes a drink of soda]. It might not. I just know that there was a time when it might have made a difference. When I needed help and could have had someone to help me. That was too long ago. Fuck it now. Burger is gone . . . your time is almost up . . . unless you wanna buy booze.

Interviewer: Let's keep going.

Resident: I know [manager] is getting ready to kick my ass to the curb. We've had so many fights over my staying. He tried finding my people [daughter] but can't and I'm not going to tell him . . . I don't even know for sure where she is. He thinks I need a nursing home, but I'll be dead long before then.

. . . . . .

Resident: Look around, does this look like a place to grow old?

Resident: White boy, your time is up . . . thanks for the burger. [Resident stands up, dusts off his pants and goes inside. The door closes.]

Discussion

This resident brings together many traditional and non-traditional notions of frailty in the excerpts of this interview. Most importantly, however, his conceptualization of frailty originates not from within himself, but from those around him--most specifically the manager of the apartment complex. The projections of frailty by this manager have contributed to the resident's current demeanor. In his diminished capacity, he falls back on the traditional notions of frailty as being old, decrepit, and worthless--like the arthritic hand he shows the interviewer. Though this resident never states how

long he has been at this housing facility, he indicates that he has spent many years residing in housing facilities across the state. These facilities--like the Section 8 in which he currently resides--offered him no services or assistance to support aging or aging-in-place. He explicitly states that no one was there to help him when he needed it most. "I did have any help. Don't have it now. And don't really think I'm going to get any. I'll just end up moving along to fuck knows where." The lack of services at non-Section 202 type housing facilities leave many elders without a "network of support" to provide assistance during difficult times of medical, emotional, and psychological transition in the course of aging. This resident has been consistently neglected and overlooked to the point of never expecting to get assistance. He lashes out at anyone within reach, including the housing manager and the interviewer. Resident 17 has spent most of his life in the "gap" of senior housing and senior services with very little real hope of ever getting out.

Case Study 5: Individual Model of Frailty

Resident 92, an 83 year old white female, lives in a south central Florida Section 221 facility that has both a low concentration and small population of elders. She lives alone, has no family nearby, but has a daughter in the state that visits three to four times per year. She has considered moving closer to her daughter, but has not taken any initiative to do so. Resident 92 has numerous health care problems, including blood pressure, heart problems, and periods of confusion. According to the manager she was meticulous in appearance and grooming, but--lately--has begun wearing the same clothes for weeks on end and acting "uncharacteristically odd." When asked about her clothes, she states, "Everything is fine." The facility manager has concerns that she is showing

early stages of Alzheimers disease, but has not been able to have the woman evaluated. Her daughter, though appearing concerned, has not made a trip to visit her mother.

Interviewer: Good morning, [resident's name]. How are you today?

Resident 92: I was talking with my friends about you. He said you were going to ask me about the war. I was a spy.

. . . . . .

Interviewer: I spoke with your manager . . . is that your friend?

Resident 92: Oh yes, I've know him all my life. . . .

Interviewer: [Interrupting]. Can I ask you about your life and aging? And how you are doing here at [facility's name].

Resident 92: Aging . . . to get old is not grand. I always thought my life would be different. I didn't think it would be like this. . . [resident continues talking about her life and growing up].

. . . . . .

Interviewer: Tell me about your life here. Are you happy with it? What do you like best?

Resident 92: This is a lonely place. I don't really have anyone to talk to. People don't come by and visit me anymore. I miss that.

Interviewer: If people came to visit, what would you do?

Resident 92: I think we should have tea in the garden [pointing out to a concrete picnic table under a tree].

Interviewer: Let's go sit under the tree. [Resident and interviewer move to the picnic table]. Do you know what frailty is?

Resident 92: Frailty . . . frailty. I remember when my mother got old . . . she died when I was seventeen. She stayed in bed all the time when she passed. My aunt--her younger sister--helped take care of her. I think that what I miss is having somebody around me. It's so nice to talk with you . . . you look just like a boy I knew growing up. He was so handsome.

. . . . . .

Interviewer: Let's go back to my question on frailty. When you hear the word frail what do you think of?

Resident 92: My mother being alone. Frailty is cold . . . it's isolation.

Interviewer: [Interrupting] You say that you feel alone . . . and isolated. Does that make you frail? Is that all that frailty is? Loneliness.

Resident 92: Am I frail? I never thought of that. I don't think I'm frail. I'm not like my mother. She was frail, but I'm not.

Interviewer: What makes you different than your mother?

Resident 92: She had people around her. I don't.

Resident 92 spends much her time alone, isolated in her apartment. Though the manager checks on her occasionally throughout the week, he usually has little time to spend quality time with her.

Manager: I just don't have time to sit with her everyday. There is too much to do around here. Fixing stuff in apartment, paperwork, meetings, other things. It could be a 24 hour job with no time off. You have to learn to have priorities.

Interviewer: Are there many residents here like [resident's name].

Manager: There is one more like her. And I'm doing everything I can to help her. That woman's daughter is more involved with her. She makes sure that someone comes in once or twice a week to help her. But I hear that's money [rubbing his thumb and finger together]. Not many around here can afford that. I can't offer them any services, except checking on them once in a while. You know . . . the world is paved with good intentions.

Interviewer: Have you thought about moving her out? What would make you decide to do that?

Manager: To be honest, I have. I'm trying to give her a little more time. I'm trying to get the daughter up here. I'm trying to find some program to help her. But if she keeps getting confused--she locked herself out of her apartment one night two months ago and spent the night wandering the complex. She though she heard thieves tapping on her windows--go figure. She can't do that. I called an ambulance, but she would not go with them. They did check her over and said she was all right. I don't know that I believe that, but hey . . . what can you do?

Discussion

For this resident, frailty is conceptualized by the individual model. Her limitations and beliefs of frailty come from her own thoughts and experiences with very

little input from others because of her isolation. Throughout the interview, she compares her life to that of her mother's, living in romanticized expectations of life and aging that are incongruous with her reality. She is cut off from people with no friends or neighbors to check on her or just stop by to visit. This fact is particularly important in that the 221 facility has few services to monitor its residents. According to the manager, this resident has been known to spend two, three, and even four days inside with little or no personal contact. "The staff is always inquiring among ourselves, 'Did you see Eva today?' If no one can confirm a sighting, we'll go and check on her. That sometimes doesn't happen for a couple of days unfortunately. We do what we can."

This resident is faced with a variety of obstacles that are slowly forcing her from her apartment. As her confusion becomes more regular and sustained, she will become increasingly needy. The manager does not have time to watch her, nor does he have the physical and safety design features in the facility to support residents with dementia. Supportive services and a service coordinator would offer some short-term assistance; but if she continues to demonstrate current levels of dementia and confusion, she will surpass the modest level of support available at the Section 221. Many managers believe dementia, psychological disorders, Alzheimers, and other personality altering conditions cannot be adequately accommodated in current subsidized housing, though many admit that facilities like Section 202 can better support individuals in early stages of these conditions and diseases.

Summary

The different types of government-subsidized housing offer supports across a broad spectrum of possibilities for conceptualizing frailty. Most residents were highly

tuned to their residential environments, the support or lack thereof by facility staff, and ability to access on-site and nearby services, like housekeeping assistance, transportation, medical facilities, or meals. Residents in very unsupportive facilities--like those of Section 8 facilities--not only did not feel they were capable of taking care of themselves as well as other seniors, but did not exhibit high satisfaction with their residential environment, fellow neighbors, or quality of life. On the other hand, residents with supportive services at the HUD facility, possessed high satisfaction with their life, facility staff, and activity levels. Residents that were least likely to refer to themselves as frail, felt that even though they required assistance, they were still independent.

The interviews presented here as case studies and the other 99 resident and 48 manager interviews that comprise this research, highlight the role of supportive services in creating and defining frailty. Frailty for most residents--though often thrust upon them as a label or diagnosis--did not influence residents in their self-reporting of frailty. Residents neither viewed themselves as frail, nor believed they were frail simply because managers or doctors declared them so. In facilities that offered supportive services, particularly high levels of services combined with design modifications like those of Section 202 housing, managers and residents were less likely to consider themselves frail or have managers consider them frail.

Solutions in Lived Experiences

To attempt to classify residents of these housing facilities as frail without examining the relationship between the environment and the individual overlooks the dynamic set of environmental, physical, psychological and social assets and deficits that comprise independence. Simply labeling residents as frail negates any affects of

supportive services that can be brought into the apartment to supplement ADLs or IADLs, the type of housing environment the resident lives in, and the opportunities present in that environment to successfully remain there.

Thus, what occurs in these four models is an intersection of personal and environmental factors that contribute to the presence or absence of frailty. These factors, listed in Figure 4.3, may seem arbitrary, but create a framework for understanding immediate person-environment interaction and the potential long-term influences in a residential environment for contributing to frailty. By addressing issues of frailty in this manner, individuals can retain control over their own health, and have the opportunity to change their life situation through community, individual, and policy programmatic interventions.

Medical	Service	Individual	Manager
Symptoms of Frailty:	**Symptoms of Frailty:**	**Symptoms of Frailty:**	**Symptoms of Frailty:**
Chronic Illness	Major/minor ADL and IADL deficiencies and unavailable services.	Incongruence between expectations and realities of aging.	ADL/IADL deficiencies and being unable to provide help.
Disability	Illness	Loss of roles and/or abilities	Taking care of themselves and unit
Aging	Mobility Problems	Lack of individuality	Mobility problems
Dementia			
Sensory Impairment			
Signs Exhibited by Elder	**Signs Exhibited by Elder**	**Signs Exhibited by Elder**	**Signs Exhibited by Elder**
Confusion, lack of mobility, poor apartment maintenance, poor nutrition.	Lack of mobility, poor nutrition, poor apartment maintenance, isolation.	Loss of control over life, not being involved in health care decisions and life plans.	Withdrawing from population, confusion, poor nutrition, and isolation.
Role of Manager	**Role of Manager**	**Role of Manager**	**Role of Manager**
To encourage resident to get services into apartment (if available option), provide assistance and monitoring him/herself, or force resident to move to more supportive surroundings.	To encourage residents to access the available services of the housing facility, the community at-large, or with family members to satisfy basic needs within the housing complex.	To encourage create a sense of individuality in each tenant; recommend service if and where appropriate.	To encourage access to supportive services without sacrificing dignity, autonomy, and humanity. Managers must realize when it is most appropriate to transfer resident to more supportive surroundings.
Source of Frailty:	**Source of Frailty:**	**Source of Frailty:**	**Source of Frailty:**
EXTERNAL	INTERNAL	INTERNAL	EXTERNAL

Figure 4.2. Factors Contributing to Frailty Based on the Four Models of Frailty.

CHAPTER 5
CONSTRUCTING AGING-IN-PLACE

> Increasingly the prospects of "aging in place"--that is, of older people remaining as residents in their own conventional dwellings even as they become frail and impaired--has become a mission of the aging establishment.
>
> (Golant 1992, *Housing America's Elderly,* p. 148)

> Aging-in-place means I don't have to move.
>
> (Resident 14)

> Aging-in-place is not having to move from one's present residence in order to secure necessary support services in response to changing need.
>
> (Manager 20)

What is Aging-in-Place?

Aging-in-place is not a new term, but it has come to take on many meanings in the last decade or two, describing a person or population growing older within a specific environmental setting. While early definitions simply focused on older persons' preferences to grow old in their own home, more recent work has expanded this traditional notion to engage a more complex view of residential settings and conceptualizations of quality of life for long-term occupancy of residential environments. Thus, aging-in-place research has begun focusing on keeping residents "at home" in places like apartment units, assisted living facilities, board and care homes, everywhere elders are trying to create and maintain their lives. Many gerontologists, including Golant & LaGreca (1994), Golant (1992), Pynoos et al. (1990), and Lawton (1980), have stressed the dynamic nature of aging-in-place in that both the individual and the housing environment must change over time to embrace the transformations in the individual and

the shifts in appropriateness of the housing structure itself. In the course of this process, the literature also highlights the importance of continuously re-assessing the person-environment fit (Golant 1984, Lawton 1989, Lemke & Moos 1989). This dynamic process becomes relevant in understanding the relationship that exists between manager and resident in the environmental setting of a government-subsidized housing project.

Literature of Aging-in-Place

In one of the introductory excerpts of this chapter, Golant (1992) defines aging-in-place as a desire of elders to remain at home. According to the Association of American Retired Persons (AARP), most seniors indicate they would like to remain in their current residence as they age. In fact, 71% of respondents to the AARP survey (2000) *strongly agree*, and an additional 12% *somewhat agree*, that they want to remain in their current residence as long as possible. In this same survey, 63% of respondents believe that their current residence is where they will always live, even when they become frail and require assistance. Many of this group believe that they can better remain at home, instead of moving to an assisted living facility or nursing home, by bringing caregivers and supportive services into their residences.

Though the AARP survey does not target low-income elders of Florida's subsidized housing specifically, similar attitudes can be attributed to this population (Golant 1999). The CASERA Project (Golant 1999) found that HUD managers and administrators valued aging-in-place for their older and more frail tenants. This value was expressed in the overall philosophy of the housing project as well as everyday policies and action of the manager and staff. HUD managers/administrators held the following views:

- Frail elders do not have to move if they can arrange for their own help (86%).
- When elderly tenants are having difficulty taking care of themselves, we will arrange for them to receive supportive services (23%).
- If affordable supportive services were more readily available, we would be more open to keeping elderly as tenants (48%).
- Our philosophy is to assist frail elderly residents to remain in their current apartments as long as possible (56%).
- When elderly tenants are having difficulty taking care of themselves in their apartments, they would not be better off in some type of group home for the aged (31%).

Similarly, residents indicated that they wanted to remain at home as they aged, fearful that a life in a nursing home would be no life at all.

Along with residents and managers, other interested groups are also concerned with aging-in-place, and avoiding premature institutionalization. This results in unlikely ties among a variety of academic, realist, business, and government perspectives.

> Philosophers arguing the right to human dignity, family members seeking to escape feelings of guilt, entrepreneurs with profit motives, and bureaucrats with their cost-containment criteria make strange bedfellows. (Golant 1992, p. 148)

Despite these seemingly incongruent motivational perspectives, each has an interest in keeping the elderly out of nursing homes as long as possible.

Residential and Managerial Responses to Aging-in-Place

The availability of affordable and supportive housing for frail and needy elders in the state of Florida has created increasing concerns at the type and level of need of this group. On the surface, programs seem readily available to "house" this group of elders, but not to support aging-in-place. The main controversy surrounding programs for this population--and really this *is* the group that needs the most assistance--arises out of the need to provide basic social welfare and support to a group that does not always realize they need aid, while maximizing personal dignity, independence, and choice.

Residents and management approach the issues of aging-in-place, not surprisingly, from similar perspectives. Residents view the ability to remain at home as having a direct connection to the ability to access services. Managers, while preferring not to be categorized so simplistically, have a service-linked approach as well.

Residents' Views on Aging-in-Place

Most of the low-income and frail seniors in subsidized housing facilities have few relocation options, particularly when compared with those in the population at-large.

> **Resident**: If you think about it, what can we really do? We stay or we move. Mr. Stevens [not his real name] has told me that I need to do a better job at taking care of myself and the apartment or I'll have to move. Where to? Where am I supposed to go? I can't move in with my son in Oregon. If I don't go to him, where to? If I could afford to bring someone in I would. I'm here because I don't have a lot [of money]. And if I did, I sure would be in a different lot. I'm screwed . . . there's nothing no one can say. (Resident 21)

Due to the fact that this population has sought subsidized housing in the first place because of low incomes, their advancing frailty will only make their housing needs more specialized and costly. This group lacks the familial resources to "count on" during crisis situations. Also, as documented by the CASERA Project (Golant 1999), this population is unlikely to have family or friends that can provide assistance, shelter, or support in times of crisis. These two factors alone make elders in this group ripe for being prematurely institutionalized when they begin showing signs of supportive service need.

Elder tenants in this research--though often not knowing the meaning of aging-in-place, or ever having heard the term--also predictably want to remain in their homes until they "absolutely have to move" or were "forced to move." Over three-quarters of the residents in this research believe that they *should* have access to assistance in a variety of

forms, even if that help is only a family member, to remain independent in their apartments.

> **Resident**: Why shouldn't we be able to get some help if we need it? And if we can afford it. We should have that, right? I know that my family would help me if they could. (Resident 21)

Furthermore, residents felt that management and housing sponsors had some responsibility in possessing knowledge on available supportive services and/or providing advice and assistance on-site.

> **Resident**: Of course they should offer us advice about staying [in the apartment units]. They [managers] are the ones who should know the best. We are trusting them to take care of us. (Resident 21)

Other residents of these types of housing projects comment:

> **Resident**: This is our home, why shouldn't we get some help to stay here. If we can do it ourselves, we would. This is our right. (Resident 52)

> **Resident**: Why wouldn't we need some help. Look where we are [living]. I'd say we need all the help we can get. (Resident 37)

> **Resident**: There are times when people need help. [People like us] don't always know the stuff you [interviewer] do. We need people like you to help us. Tell us. Help us. Let us stay in our homes. (Resident 71)

Most residents of government-subsidized, low-income housing projects place an inordinate amount of trust in their managers, expecting certain levels of knowledge about keeping them in their apartments to age-in-place.

Attempting to relocate frail elders from independent, rent-subsidized housing provides a whole new set of complications. Without having some form of supportive services linked to the "independent" housing facility, many elders that become service dependent face the prospects of having to move. Subsidized congregate housing like Section 202, or other long-term care options like high-quality nursing homes, are less

likely to accept residents from independent housing for a variety of reasons (Managers 22 & 48). As one group of gerontologists and housing expert notes:

> The best congregate facilities and long-term care institutions have the highest demand for their vacancies, and the managers apparently feel that priority should go to those elderly people who have been forced to leave conventional housing due to advanced frailty rather than those living in subsidized housing for the functionally independent. (Heumann & Boldy, 1993, p. 13)

This view is often based on the false assumption that subsidized senior housing includes supportive services. This is often not the case, however; and contributes to the premature institutionalization of many low-income frail seniors. In fact, history demonstrates that tenants in federally assisted housing have required services that are not always available to them. For example,

> [One study found that] approximately one third of public housing tenants said that needs for assistance with transportation, shopping, housekeeping, and meals were unmet. Because almost two thirds of elderly residents in federally assisted housing lived alone compared to just one third of elderly persons who lived in housing without federal assistance, the elderly were considered more reliant than others on services from the forms system to maintain their independence. (Pynoos 1992, p. 166)

Typically, residents have three aging-in-place choices, regardless of the housing type. First, residents can hide their problems from themselves and the manager to avoid confronting the issues that limit their ultimate residence in the housing project. This is quite common, particularly with residents that have limited knowledge of the benefits of a supportive housing project. Second, residents can work to avoid "worst case scenarios" by securing supportive services. Residents begin to feel that they can "regulate" safety into their lives by getting assistance with day-to-day activities. Most often residents state, "I'm alright as long as I don't have to bathe alone" (Resident 62), or "I only worry when I don't have the help I need around the house" (Resident 84). Lastly, residents that do not get support are forced to move to new residential settings.

Residents hide problems from managers

When residents of independent housing projects are confronted with day-to-day living obstacles, they have very few real options. Some elder tenants attempt to hide their problems from the manager and ignore the situation. Surprisingly, this happens quite often.

> **Resident**: I just don't have the energy to do it anymore. I can't keep up with the cleaning and taking care of myself. It's just not worth it to me anymore. But all I can say is that I've gotten away with it for almost a year. I know that he [manager] has been watchin' and wonderin' but he couldn't know for sure. He just couldn't know for sure. (Resident 9)

This often occurs in facilities that are not designed for elders, or that do not have adequate mechanisms to provide for interfacing between manager and tenant. Tenants fear that service dependence labels them as frail and targets them to be relocated. For managers, this situation can be a double-edged sword.

Residents secure services for independence

The second option is for the resident to receive services to preserve their independence. Subsidized housing like Section 202s, Section 221s, Section 236s, and Section 8s can link a broad spectrum of services with conventional apartment units or rely on residents to secure their own services from the community. The types of facilities that are included in this category can include all forms of housing developments with varying levels of services.

> **Resident**: If I didn't have my helper around the house, I don't know what I'd do. She helps me with cooking and cleaning. If she weren't here, I know that Mr. Ellis [not his real name] would make me move. (Resident 11)

In the Section 8s, 221s, and 236s many of the services are limited to a few key areas, whereas the more supportive environments--like Section 202s--offer a more comprehensive set of services.

Residents relocate to another housing environment

The third option is for the resident to be relocated to another housing environment. This can include more supportive housing like a nursing home or the home of a friend or family member, though unlikely because extended family members or friends--if poor--lack the time, housing capacity, and supportive services to provide assistance to elderly friends or relatives. Although families below the poverty level do take in elderly relatives, an increasingly likely outcome is that families cannot cope with the demands of providing long-term care and, ultimately, seek the only available option--the nursing home.

Managers' Views on Aging-in-Place

Though aging-in-place is popular among residents, a much lower percentage of Florida's HUD managers believe that residents should be able to remain in their homes regardless of the circumstances. Management's views on this issue are key to the supportive nature of the housing project and the available supportive services. Managers approach aging-in-place matters in one of three approaches--the inactive approach, the reactive approach, or the proactive approach. With the inactive approach, managers typically offer no support to keep residents in their apartments. On the other hand, the reactive and proactive approaches offer varying levels of support. Where the reactive approach only addresses needs as they arise, the proactive approach works to supply services before crisis situations arise.

Some managers do use service utilization to judge elders' independence. Others feel that:

> **Manager**: [This type of situation] is the worst because we cannot be everywhere at once. Often we overlook those who need us most because we get busy with

> other things . . . an inspection or something like that. It's not something to be proud of. But things do get by us. Residents hide little things and after a couple of weeks, or a month, of neglect . . . well suddenly you've gone from a teensy-weensy problem to a big pain in the ass. (Manager 6)

These managers tend to focus the greatest amount of their time and attention on "bricks and mortar" issues because they believe their residents to be independent and self-sufficient. Often when "crisis" situations arise, elders are facing many "snowballing" obstacles to their independence, instead of only one or two minor ones. Handling residents with this fear not only creates problems in the present, but for future interactions with a manager, especially those that are really trying to help the elder.

Roughly two-thirds of all managers supported their elders in one form or another to keep them in their apartments. This notification of "support" has a variety of meanings and takes many forms, including: (1) encouraging words of support, (2) providing some services themselves, (3) bringing services on-site, or (4) providing some means to access community-based services; moreover many of these managers have both implicit and explicit "rules" guiding their beliefs.

> **Manager**: It really depends. I can only help so many of them [residents. If too many need help--and hey I'm only one person working here [Section 8 facility]--I can only help two, maybe three. After that I really have to start helping them move out . . . move on. We just aren't that kind of place. (Manager 2)

Other managers, across the broad spectrum of housing types, indicate they have similar viewpoints.

> **Manager**: We have some services, but [when] things get too hectic and the [resident] doesn't take care of herself. I try to get someone in to help but here [Section 8] we can't be all things to all people. When they are no longer independent according to HUD, they go. (Manager 17)

> **Manager**: We work to get our residents the services they need, even if that means moving them someplace more appropriate for their needs. My goal is to help these people [service dependent elders] live a quality life. Sometimes we can take care of that here, sometimes not. (Manager 24)

> **Manager**: I want our residents to get the services they need. And we provide them with a good selection, all of the necessities. The support is to help them live their lives as they--or maybe their children--would like them to. Our job is to keep them safe. (Manager 31)

> **Manager**: [Facility] has pretty good services. We have good relationships with churches, the food bank, some doctors. We do what we can, but like Ellen [not her real name] sometimes we just can't do enough. That's more our fault than hers. I really wish we could do more, but I don't have enough units with grab bars and [other physical modifications] or access to the types and amounts of services we need. (Manager 29)

> **Manager**: I've been lucky that we have been able to get enough things done to keep our residents here. We've had a couple of construction companies do modifications to some units. That's always nice. I don't know . . . right now . . . what would make me move any of my residents. Right now, we can handle anything. That can change--overnight. We always have to play it day-by-day. (Manager 27)

Many housing environments have the physical components to support the most dependent elder tenants--large door frames, ramps, grab bars--and only lack connections with service providers. Even if managers can cope with the dependent elders, they continue to indicate that they will continue encourage a resident to move elsewhere--usually to a nursing home--when their assistive services change the demeanor of the housing complex.

> **Manager**: I want my residents to get the help they need . . . here [at this facility] and wherever they choose to live. Though the services they use must not attract the attention of other residents . . . I mean they [residents] cannot turn us [facility] into a hospital. They must continue to be independent. (Manager 33)

This administrator highlights one of the managerial approaches to aging-in-place: I'll be reactive, but not all the time. This managers places limits on how and when he will react to the needs of his residents, carefully clarifying that independence and facility demeanor are very important.

Even with clarifications and limits, the interest to keep elders at home and age-in-place is strong among Florida's HUD residents and many of their managers. The

challenge of translating beliefs into actions is the difficulty managers face--providing the necessary supportive and assistive services to facilitate long-term occupancy of apartment units.

Examining Issues of Aging-in-Place

There are many definitions of aging-in-place, like Golant's (from the opening series of quotes), and this research attempts to understand which--if any--apply to issues that center on Florida's low-income, rent-subsidized housing managers and their desire, or ability, to keep residents in their apartment units, rather than moving them to more supportive environments like nursing homes. According to managers and residents, the issues surrounding low-income elders in rent-subsidized housing and their desire to remain in their homes, hinge--to a greater or lesser degree--on three important factors in the minds of managers and residents: facility types, access to services, and conceptualizations of frailty. These factors determine how managers respond to residential concerns over aging-in-place. Understanding how each of these three components impinge on each other provides a greater comprehension how managers judge the abilities of their frail, elder residents to age-in-place in Florida's rent subsidized housing.

Facility Types

The categories of facilities distinguished in this research make it possible to assess the implications of aging-in-place issues. Distinguishing facility types provides a context for judging the physical plant's ability to accommodate residents with physical, mental, or supportive difficulties. Recognizing the differences among these facility types also provides insight into the expectations managers and support staff will have toward elders,

their problems, and the services required by this population. Much can be learned regarding these issues by examining the staff of a housing project, how they interact with residents, and--*most importantly*--what they expect from the residents. Understanding in this way goes far beyond "bricks and mortar" to view the inner decision-making process of the manager and staff themselves.

> You'd be amazed at what you can learn simply by looking at the building. I don't just mean the physical plant, but what HUD says we are. Going back to the buildings guidelines can tell you a lot. (Manager 3)

The demand for services is most likely to be addressed in highly supportive, homogeneous facilities like Section 202s, but supportive services are present across a vast number of heterogeneous, or mixed population, senior housing facilities as well. In facilities like Section 236s and Section 221s or more supportive Section 8s, managers provide services as stopgap measures to assist the moderately impaired.

> What we've tried to do is provide very minor levels of service to our needy tenants. Because of our situation, we can't do everything, but if they are only confronting basic . . . low-level . . . types of problems, I am will to live with that. I can help them access some housekeeping services . . . maybe some grocery or errand services. (Manager 6)

The more supportive facilities, like Section 202s, are not only physically designed with elders in mind (with grab bars, other physical design features, dining room, and transportation), but they have staff that are familiar with their needs, and have additional training to support them. Management has an understanding of what to expect as the different age groups move through the life course. They are prepared and able to secure needed services, provide assistance with long-term planning, and create a safe and secure environment in which to age. To their credit, this type of facility offers a proactive approach to dealing with the complete needs of elder tenants in the project. Adopting this approach typically provides on-site or access to community services. The ability to

provide this access is a key indicator as to how supportive an environment can be made for frail elders, and their interest in facilitating aging-in-place.

In contrast, housing other than Section 202s--projects like Section 8s, Section 221s, and Section 236s--are not physically designed with frail elder tenants in mind. Additionally, other factors like little, if any, gerontologically-based training for management and staff, as well as, a lack of familiarity with elder issues further impede the prospects of aging-in-place. For these types of projects, managers have little time or energy to focus on the concerns of elder tenants, particularly when faced with staffing shortages, bottom lines, and tight budgets. For frail elders living in these housing projects, they have little guidance on long-term care issues or understanding of the value and role supportive services can play in their life.

Along with the facility type, other social and economic characteristics of the building are important to consider when determining support for aging-in-place. The population--the simple numbers of elderly in any project--and the concentration of elders--the percentage the elders comprise in the facility--also influence the long-term housing potential of this population. Residential environments that have high numbers and concentrations of elders, or are specifically designed for them--like the homogeneous populations in Section 202s--offer the greatest opportunities to provide support and services. Other important components of this type of this comprehensive environment include: service coordinators or case managers, and on-site and community supports allow these facilities to take full advantage of economies of scope and scale to reduce supportive service costs and bring additional services on-site.

> Managers report that service coordination and availability can help avoid damage to or decline in property value, improve relations with and quality of life for

> tenants, and allow managers to devote more time to the tasks of building management, with which they are more comfortable. (Feder, Scanlon, & Howard 1992, p. 62)

Facilities that do not have high populations or concentrations of elders, that are not specifically designed for elders--like Section 8 housing and to a lesser degree Section 221 and 236--or that are not homogeneous, offer fewer opportunities to provide services. Those that are service available are typically more expensive and less comprehensive in addressing the needs of residents.

Those inactive managers and their facilities that do not provide strong service programs also are less likely maintain long-term residence of frail elders. Often, without an impetus from management, or other support staff, like a service coordinator, few elders will attempt to secure services from the community at-large in these facilities.

> **Resident**: I would have never known who to call or what to do to get some help. Without help from the manager, I would have been hauled off. What they [manager and his staff] do is a godsend. (Resident 71)

This housing type, will not create an environment that facilitates low-income elders to age-in-place, and ultimately will trigger events that necessitate management to move them into other facilities, or relocate them to the home of a family member, if available.

> **Manager**: We try to move residents in with family members if we can. If they don't have family we typically try to relocate them with one of the nursing homes . . . sometimes they are moved a little further south into Miami . . . but they all go to good [nursing] homes. (Manager 2)

In addition to facility type, two other important elements of aging-in-place are: access to services and conceptualization of frailty. Without timely access to services, few residents will be able to maintain long-term occupancy of their apartments in Florida's low-income housing projects. Secondly, understanding how managers conceptualize and

deal with frailty indicates their expectations for providing services to this population and "shore up" unmet needs.

Access to Services

Recognition of the need to integrate supportive services into senior housing is not a twenty-first century invention (Bennett, Starr, & Zierman nd). Linking subsidized housing and services offers enhanced community living for older people whose needs may be significant, but whose options for meeting them are limited. With rising health care costs, the aging of the current population, and impending baby boomers, there has been considerable interest in the use of health and medical services by the elderly. Although often viewed as a humane alternative that defers costly dependence and institutional care, the use of supportive services has not received significant research attention in low-income housing. Maintaining older adults in their homes and preventing premature institutionalization are policy objectives that contribute to the demand for on-site and community-based services in subsidized, low-income housing. Because these seniors are more likely than elderly homeowners to have functional problems, the need for services is greater in housing facilities that cater to low-income elders than in the community at-large. These types of services not only improve health and long-term viability, but improve quality of life for the residents as well.

These types of services usually provide "momentary brakes" to an inevitable slide that will eventually move the elder out of these facilities. Understanding the role supportive services play in aging-in-place is critical to maintaining elders in housing facilities and minimizing events that are signs to managers that seniors must be re-located.

Conceptualizations of Frailty

Conceptualizations of frailty are closely linked to a senior's ability to access services to "shore up" unmet needs in day-to-day life. These provide a culmination of housing administrators' experiences and expectations with elders within the confines of the housing facility. Those facilities that provide the most support, are less likely to label elders as frail simply because they do not demonstrate as many "triggering" events. Housing complexes that have heterogeneous populations, or "mixed" populations, tend to identify signs of frailty much more readily than specialized, homogeneous housing facilities like Section 202s (Golant 1999). As one Section 202 housing manager notes:

> Because of the way we support our residents, staff sometimes forgets that they are frail. We try to emphasize autonomy and want them to do as much as they can. I try not to judge them by what they cannot do, rather what they can. The services that are brought in help with what they can't accomplish. After a while, you forget they are not the ones cooking dinner, cleaning the apartment, or getting their groceries. . . . Isn't that the way services *should* work? (Manager 23)

Knowing that people of any age want to remain in their homes, it is not surprising that elders consistently choose to live independently and remain where they are, despite apparent economic or health-related reasons for relocating. These three factors provide the greatest insight into how supportive a facility is likely to be for aging-in-place, and how much assistance will be available to encourage and support the residents to do so.

Summary

These three facets--facility types, access to services, and conceptualizations of frailty--play a critical role influencing aging-in-place because it is the housing environment and its impact on the resident that shapes the relationship between manager and tenant. If the frail elder feels comfortable and supported by the environment, they are less likely to generate "triggers" that cause managers to consider relocation. In all the

three resident's options for dealing with aging-in-place come together very tightly to influence long-term residence in any of Florida's subsidized housing complexes.

Approaches to Aging-in-Place: Management's Perspective

The methods of dealing with aging-in-place are more likely related to the housing type and factors present within that housing type than any other influence. Through interviews with managers and residents, three managerial approaches to aging-in-place emerged--the inactive, reactive, and proactive responses. Each presents a different set of managerial interests and approaches accommodating frail elders in their housing facility. The different characteristics of each managerial type can be viewed in Table 5.1.

	Inactive	Reactive	Proactive
Facility Type(s)	Section 8, Section 236, and Section 221.	Section 8 and Section 221	Section 202
Population Type	Mixed populations.	Mixed populations.	Seniors only.
Supportive Service Availability	Community-based only. No contracts.	Some on-site. Possible contracts with community-based providers	Extensive on-site and community-based services. These facilities have contracts with supportive service providers.
Likely Long-term Occupancy	No.	Limited.	Yes.

Table 5.1. Characteristics of Managerial Approaches in Subsidized Housing.

Inactive Approach

This approach is taken by facilities that do not to address aging-in-place issues. In the **inactive approach**, managers choose to do nothing for their residents because the facility is specifically designed and operated for tenants with certain minimum levels of health and mobility. In these types of facilities, when residents cease meeting these

requirements of independence, they are likely to have to move to more supportive facilities.

For low-income housing facilities that do not have high populations and/or concentrations of elders, or as a consequence strong commitments to providing services--like Section 8, Section 236, and Section 221 (d) (3) and (d) (4)--many choose not to provide supplemental services. Other projects choose to create supportive environments, or have limited supports, because the costs do not benefit major segments of the residential population; they are expensive; or they change the overall demeanor of the complex.

Reactive Approach

The second option, the **reactive approach**, is for the residential facilities to provide supportive services and design amenities to meet their aging tenants on an as-needed basis--often responding to a crisis. This option encourages residents to provide their own services or select from a limited number of services available on-site; but the facility limits the types and kinds of services brought into the apartment units to ensure environmental congruence is maintained and the complex does not achieve a "clinical or medical" demeanor. Most managers warn about bringing too many or inappropriate services on-site because they do not want their housing projects "medicalized," nor do not want to alienate their more independent elder tenants.

Without supportive service programs for their frail elders, managers selectively respond to problems as they are brought to their attention. Despite the fact that many facilities have services available, many residents "fall through the cracks" before they are able to access needed services.

This approach was most often seen in mixed population facilities, that is, facilities that have both young people and seniors living together, like Section 8 or Section 221. Commonly these facilities try to encourage elders to age-in-place with selected services, but placed limits as to exactly how much support can be brought in the project. They usually require residents to relocate to more supportive surroundings when they can no longer manage day-to-day activities or pose a danger to other facility residents.

Proactive Approach

The third option is the **proactive approach**. This model is the most supportive and accommodating of the three, and is mostly found in Section 202 facilities. These facilities have a large set of services available on-site, some even providing service coordinators to assist residents with problems, secure needed services, and monitor their health and physical abilities. This model provides for interaction between residents and managers on a frequent basis through a staff member, usually a service coordinator, to determine appropriate essential services early in the "cycle of need." By confronting obstacles in a timely manner, seniors can maintain independence, as well as health and well being. While the advantages over the **inactive approach** are obvious, this model provides a more structured environment than the **reactive approach**. This supportive "net of services" not only compensates for deficiencies of need like ADLs and IADLs, but also maintains a consistent and constant method to supporting ongoing service requirement.

Summary

Of the three models, the **proactive approach** offers the greatest hope for supporting frail elders to age-in-place by providing services for the dynamic changes that

accompany aging. This long-term approach to aging-in-place has at its core the objective of providing maximum care and support while maintaining autonomy and independence. The attempt to respond to frailty in this type of housing environment provides a cost-efficient means of providing alternative supportive care. The other two models leave elders vulnerable not only to the changes associated with aging, but to premature institutionalization, poor health care, and diminished quality of life with no real hope to stay in their apartments when they become more vulnerable.

Aging-in-Place: Case Studies

The six brief case studies and the excerpted sections of interviews examined in this chapter engage the questions pertinent to exploring aging-in-place with the two groups of actors. Do they have a meaning for aging-in-place? What actions or behaviors contribute to aging-in-place? What types of services can promote aging-in-place? The following "life experiences" illustrate issues confronted by management and residents in Florida rent subsidized, low-income housing facilities. The following "stories" illustrate issues confronted by managers, when dealing with aging-in-place issues in spectrum of housing projects engaged by this research.

The rationale for comparing Section 202 housing facilities to other housing types follows that of the previous chapters. These facilities offer the maximum supportive environment for elders to age-in-place, including programs such as service coordination, meals, recreational activities, and other programs. These six case studies are selected for inclusion here due to their illustrative nature of the three models of aging-in-place. Because most low-income elders do not live in Section 202 housing facilities, this type of comparison makes readily apparent the contrast in available services and support.

Generally, members of this subgroup of elders are going to be living in heterogeneous populations with few design modifications and supportive service opportunities.

The six case studies presented here are representative of the 48 sites visited. Case studies 1 and 2 illustrate the **inactive approach** to aging-in-place in Section 8 housing facilities. These two case studies represent the most unsupportive options for frail elders to age-in-place. Managers provide few, if any services, and encourage residents to move to more supportive housing when they are no longer independent.

> Consequently, if tenants became frail, they were expected to move to more supportive housing settings such as board-and-care or nursing homes set up and licensed for persons with ambulatory problems and in need of personal assistance. (Pynoos 1992, p. 160)

Case studies 3 and 4 illustrate the **reactive approach** in a Section 8 and Section 221 housing facilities. These two case studies represent a "middle-of-the-road" approach to providing services to elders. As indicated by its name, this model of aging-in-place reacts to the residents' needs, by providing services after incidents have already taken place. By far this approach is the most common in the subsidized housing facilities in Florida.

> [Facilities have] progressively added services over the years in relations to the decrease in health of both original tenants and the newly admitted tenants, but he overall pattern was a patchwork of services that were relatively unplanned and uncoordinated. (Pynoos 1992, p. 166)

The last two cases studies (numbers 5 and 6) demonstrate the **proactive approach** to supporting aging-in-place. This model demonstrates the highest levels of support for keeping elders in their homes. Often this occurs in Section 202 housing facilities because they have a homogeneous population, they have the opportunity to take advantage of economies of scale to provide the widest selection of services to proactively address

needs of elders. This housing type also has the greatest possibility of offering the assistance of a service coordinator to help seniors procure needed services.

> . . . the Resident Services Coordinator [aka a service coordinator] surveys all residents to determine desired services and arranges for the services residents are willing to pay for. (Sheehan 1992, p. 24

Case Study 1: Inactive Approach

Manager 35 operates a panhandle Section 8 housing facility that has a small population and low concentration of elders. There are eleven seniors out of about 60 residents. The facility has never had more than fifteen seniors at any one time, but the manager expects that the number will increase over the next three to five years. He provides no services to his elder tenants because "to live here means that you are independent" and "if you can't do that, then you no longer live here." He doesn't have time to worry about elders getting services because he has other concerns like maintenance and operational responsibilities. Though he says he "feels sorry" for some of the residents, he cannot get attached because "as quickly as one is gone, another comes through the door." He views this facility as a "final stop" in independent living, believing that seniors "go from here right into a nursing home [to die]."

> **Interviewer**: You say that you do not provide services of any kind. Do you think that limits your ability to have long-term senior residents at this housing project?
>
> **Manager**: This is an independent living facility, according to HUD. That means that to live here, you have to be able to take care of yourself. When you can't do that anymore, you have to leave.
>
> **Interviewer**: You make it sound cut-and-dry. Is that for you or the resident?
>
> **Manager**: It don't matter to me. Those are the rules. I don't ever have to think about, whine to residents, beg family members. I guess that it makes my life easier. I don't ever have to argue with them [residents] or listen to sob stories. I make it clear to them when they move in. If you ever . . . and I do mean ever don't take care of the apartment . . . or themselves, they have to go. There are so

many other things going on . . . things that are variables . . . that this [dealing with residents] doesn't have to be one. I make this set in stone. No buts or ifs.

. . . . . .

Interviewer: Do you move many people out?

Manager: I've moved a few. One woman moved out this past month. She was not keeping the apartment clean. I made a spot inspection. Things didn't look so good. I gave her a day or two to clean it up; and it wasn't. We had a talk and because of a couple other things I found out. She was moved out.

Interviewer: What other "things" contributed to her moving out?

Manager: I told you at the beginning that I would not get into specifics. Let's just she had other health problems.

. . . . . .

Interviewer: What about services that could have helped her keep her apartment. Housekeeping services and the like? Wouldn't you let her stay with help?

Manager: That's not what this place is all about. You've already forgot what I told you thirty minutes ago. This place is independent. No services are brought in. The other people don't want to see maids coming in to help out. Other people don't want a line of people going in and coming out of someone's apartment. This is how it is.

Interviewer: Would you feel different if they made supportive service arrangements on their own?

Manager: What they do themselves I can't say too much about. But most people don't do that. If they can't take care of themselves, most can't figure out who to call to get help. In the long run though, I think I'm helping most of them. They know that to stay here, they have to do things themselves. I think this makes them try harder . . . you know work to get things done. This helps them.

Discussion

In this case study, there is very little interest or understanding of the issues of aging-in-place. For this mixed population living facility, and others like it, the emphasis is not on maintaining elders in their homes; rather it is simply about providing shelter--even if on a temporary basis. Based on the conversation, it is difficult to say whether the

manager has any empathy for his residents, despite the statement about "feeling sorry" for some of them. He judges himself to be a model of efficiency and rules by laying out clear expectations of continued occupancy. According to one resident:

> I can't really say anything about aging-in-place. I know that this is not where I will live out my last days because Mr. Thomas [not his real name] has said that we have to move out if I can't take care of myself. (Resident 53)

When the residents can no longer conform to those expectations, they are forced to leave. Obviously, there are few expectations on anyone's part who lives in this residential environment.

The primary problem of this approach to aging-in-place is the fact that residents attempt to hide their deficiencies from the manager, compromising their own health and the quality of the housing environment. One resident from this project states:

> I won't say anything to anyone, especially the manager. I know that if he finds out I'm having problems, I go and I don't want to do that. (Resident 9)

By employing this residential option to aging-in-place, this tenant has no support or anyone to turn to for assistance. The reality of this situation is that this elder is only hurting himself in the long run by deceiving management and ignoring potential health issues; and that problem is only compounded by the lack of support found in the residential environment.

Unfortunately, the dilemmas presented by this case study illustrate a lose-lose situation for residents in that they have no one to count on in times of need, nor do they have a long-term residence. For managers, this seems to be an absurd waste of shelter and potential for aging-in-place in favor of an unrealistic compression of morbidity for senior tenants.

Case Study 2: Inactive Approach

Manager 33 operates a north central Florida Section 8 housing facility that has a small population and low concentration of elders. The seven elders are labeled as "independent," though he believes that two will be moving out shortly due to "diminished levels of activity." According to the manager, the elder population is such a small segment of the population that it is economically unfeasible to bring services into the complex. In addition to the lack of interest in services, the managers has few "elder ready" or disabled units to accommodate seniors.

> **Manager**: Right now, we have less than 10 seniors in this complex. Many of them are living a safe and independent lifestyle. This is supposed to be an independent facility. I have a diverse population--single mothers, couples with kids, older couples, and a few very old people. Most of them women [continues to talk about resident population]. . . .
>
> **Interviewer**: You don't think it's important to provide services to your senior population?
>
> **Manager**: If I provided services to everyone here, there would be no end. I work the guidelines [from HUD]. This is what I'm being told to do. Other places offer more supportive stuff. That's not this place. Besides, it's too expensive. To get people [services] to come all the way here . . . naw it don't work . . . these people can't afford to feed themselves half the time. It wouldn't work. I've tried "bending" the rules in the past and all it got me was hot water and static.
>
> **Interviewer**: Can you give me an instance?
>
> **Manager**: Half these people don't care. You try to do something nice and they bitch and complain. Once they get in here, they think they're gonna stay til the pine box hauls them away.
>
> . . . . . .
>
> **Manager**: There was one resident who had someone coming in to help her. I think that was about three or four years ago. I had nothing to do with it. Her son or daughter must have gotten her [caregiver]. Eventually, she got bad . . . not taking care of the apartment. It was just too much for this women [caregiver] to take care of everything. When I had to ask her to move it was a catfight. She was just not going to go. Her son or daughter, I don't remember which, kept saying that she had "help." Well, the help wasn't cleaning up the shit on the floor. The

help wasn't keeping the apartment from stinking to the high heavens. People just started complaining. The women--the mother with two kids--that lived next to her complained that she [the resident] would scream at night, or moan, or some such thing. Everybody had had enough. I had enough.

Interviewer: So that experience soured your perception of supportive services?

Manager: Damn, you're not listening. Like I said, it's not me. I just follow the rules. This is what we are. This is how we work. This is what I do. It's clear to me. It's clear to my residents. Now I've given you enough of my time today, you're going to have to go.

Interviewer: Do you think it's important for these residents to get supportive services . . . say in another type of housing development?

Manager: If you want me to say that services are an important thing . . . yeah, sure they are. Are they what's needed here, no. This just ain't that kind of place. You've got me beating a dead horse . . . come on. But . . . off the record and I do mean off the record . . . maybe this ain't the best place for the seniors to be. Now go, I've got work to do.

Discussion

This case study, like the one above, exemplifies the **inactive approach** to aging-in-place by managers. By adopting this approach, the manager is giving himself "a way out" of having to deal with the service issues of his tenants. Instead, he is choosing to work within the HUD guidelines for the Section 8 facility to facilitate building operations, rather than maintaining the residency of seniors. Interestingly, a Section 202 housing manager notes:

> Watching over tenants--so to speak--is not an easy task, especially if you are doing it yourself [instead of having a service coordinator do it]. It takes time away from other jobs . . . project-related things like the building, paperwork, management duties. . . . Some managers live behind the rules and try not to get involved. That's neither good, nor bad . . . just how they do things. (Manager 23)

This manager, like Manager 35 in case study 1, provides clear expectations to his tenants, but these expectations are not without their own problems. Tenants that know they

cannot live up to the independent expectations of the facility attempt to hide deficiencies from the manager and his staff.

> **Resident**: I know that [manager] would evict me if he knew of all my problems, but he doesn't. Right now my daughter comes in to help me two or three times a week. That's seems to be doing the trick right now.
>
> **Interviewer**: How long do you think you can keep this up?
>
> **Resident**: I don't know. He has made it clear he will move us out if we can't do things ourselves. He is moving two people out right now. This isn't the best place to try and live and be old. Old people need more help. I know that I do.

Ultimately what happens in this situation is that resident's needs go unaddressed and unsupported. In the long run this creates a more detrimental situation for the elder, his health, and quality of life. Instead of encouraging, or perhaps forcing, elder residents to be independent, managers of the **inactive approach** are dooming frail elders to life of neglect, need, and potential health problems that could otherwise have been supported and alleviated.

Case Study 3: Reactive Approach

Manager 2 operates a central Florida Section 8 housing facility that has a small population and low concentration of elders. She works very hard to keep her 16 elders at home, but, recently, has been confronted by several seniors presenting situations that she--and the available services--could not mitigate. She is frustrated at being "forced" to move her tenants into other housing environments and wishes she could do more. She has continued to develop programs accessing community-based services in the area. "Though we can't offer much as [sic] on-site, there are several good programs run by churches that have given us support."

> **Manager**: You know you've caught me at a bad time. I'm not really having a good time with some of my residents. I've got a couple that are giving me fits.

Interviewer: Yeah, I heard you just had to move two long-time, senior residents out. Tell me about that.

Manager: Well, without getting into names, or specifics . . . two residents just left us. One was moved in with a family member, the other left for Turnbull Hospital's [not the real name] nursing home wing. Each presented us with some challenges in trying to accommodate them with services, at least initially.

. . . . . .

Manager: The one who left us to go live with family had been show signs of dementia that were getting progressively worse. Tom [not his real name] spent three or four years here. He helped others throughout [the housing facility]. In fact he used to baby sit for some of the single mothers. About nine or ten months ago, he began getting forgetful. As these brief forgetful episodes became more frequent, he began locking himself out of his apartment, losing children. None were really lost, thank God, but he wasn't watching them like he should. Slowly his apartment was not being cleaned. He wasn't changing his clothes. More recently, I found out he wasn't eating. His family wasn't keeping an eye on him. They would check on him every month or so. I managed to get help from the local Catholic Church. We got him into a program that provided housekeeping assistance and someone to wash clothes and do errands. That worked out for a while. Tom seemed to be stable. Doctors were monitoring him. I thought things would work out.

Interviewer: I know you are a Section 8 facility; what kinds of services could you provide to Tom? How did you try to help him?

Manager: Well, I tried to keep an eye on him. You know, stop by more and check up on him. But that did not always work out too well. There were times when the caregiver from the church was not there and he would not open the door. I didn't always push him, but eventually I started insisting to see his apartment. After he got the housekeeping assistance, things stabilized. It was another couple of months before I found out that Tom had something like Alzheimer's. About the time we all found out, he started into another set of episodes. He was acting strange, would not eat, walking around the house at all hours. The caregivers could not get him to settle down for the night. They started worrying that he would do something to hurt himself. I really started to think that too. When I realized he was really too much for us to deal with, I started talking to his son. He didn't have a lot of options, they are trying to raise one of their daughter's kid. You know, nobody really knows how to deal with these problems, and really this place isn't really prepared either. Seniors needed some place just for them--I know about 202s, and that's really what we need more of. . . .

Interviewer: How did you go about getting Tom into a better environment?

Manager: It took about a month to get everything set up with his son. They moved him down to live in their house, about 200 miles away [from here]. During that month . . . Jesus . . . I didn't think everything would come together. I watched over him like a mother hen. I know his daughter-in-law was up here off and on every week. Someone was staying with him almost every night and I would try to keep an eye on him during the day. I almost can't believe that we did it.

Interviewer: I know that you have said that you work hard to keep your seniors safe at home. How good are Section 8s at doing that?

Manager: That's a tough question. I do what I can. Like with the resident who went into the nursing home. Mary was tough. She did not want to go. She begged us to give her another chance. It was almost more than I could bear. She has no one except us. She has been in and out of the hospital for the past year or so. She was last in Turnbull, a skilled nursing facility, about six weeks ago. Slowly, she became bed bound without anyone really knowing it. Suddenly, one day I went to talk with her and she couldn't get to the door. After looking around and realizing that she had not been out of bed for a while, I talked to her about what we could do. Unfortunately, I couldn't get services to her as quickly as she need. We tried to work around some of her problems, but things just weren't getting taken care of.

. . . . . .

Manager: As much as I hated to do it, I found her a bed at Turnbull. She will receive better attention there. You just don't realize what it is like trying to keep an eye on residents like this.

. . . . . .

Manager: Section 8s just aren't equipped to deal with this range of problems. If you know anything, seniors really need to be independent to live here. Once that independence starts going and our available services can't fill the gap . . . they really need to start thinking about moving out. I try . . . I really do . . . to get them services they need, but we just are like that. That's why God made 202s and the like. The seniors that need the most help need places like that.

Discussion

This case study brings some of the shortfalls of the **reactive approach** to aging-in-place to the forefront. Simply trying to support elders as they present service needs, does not adequately address the core of the problem. For this manager, running around "putting out fires" almost forces her to ignore central problems in the lives of her tenants,

issues surrounding the upkeep of the project, and other duties of the manager. She does not have the resources to create a strong program of services, so there is little hope of being able to take care of her frail elder tenants.

Though the two sets of circumstances portrayed in this case study are extremes, they occur much more frequently than one might expect. The modest services provided through community outreach offer significant improvements over the **inactive approach** demonstrated in case studies 1 and 2. Despite these improvements, however, these situations portray the supportive levels present in homogeneous facilities like Section 202s and the potential support of a strong network of services made available from both on-site and community-based programs. Even this manager realizes the importance of 202s by her last comment, "That's why God made 202s and the like."

Case Study 4: Reactive Approach

Manager 16 operates a Section 221 housing facility that has a small population and low concentration of elderly tenants--roughly estimated at 20. She has spent the last three years improving service linkages in the facility, offering four key areas of assistance: housekeeping, shopping services, health services, and a meals program. The meals program is a partnership with an offsite religious organization. While not as complete as more supportive environments, like Section 202s, these services have been needed by many of the residents to keep them in their apartments. Currently there are no other programs that can be incorporated into the housing environment due to cost or lack of availability, though some residents do need other areas of assistance. Currently this manager, and her staff, is trying to address the most pressing--and most broadly needed--

areas of support. According to her, "Without a bottomless pit of money, or very generous benefactor, we cannot do any more than we are doing now."

Interviewer: What types of services do you offer to your residents?

Manager: The current package of services brings together three core homemaker programs--housekeeping, meals, and shopping, and a health care service. Those four programs have been the most requested, or I should say *needed.* Most of our residents need one or more of those services. That is not to say that *all* our residents need those programs, but times they are a changin'. Our residents have started demonstrating greater need for assistance in these areas. I don't know what you've found at other housing facilities, but a fair percentage of our seniors have been here for a while. To grow older is to need services.

Interviewer: Can you estimate the number or percentage of your residents that use your programs?

Manager: I guess about 20 residents or so. That's about one-fifth of the total resident population. That may be an overestimate, but it's in the ballpark. Probably less.

. . . . . .

Manager: Right now, we are trying to keep the residents in the homes with these services. I think that we are running a bit behind the eight ball, if you know what I mean.

Interviewer: Not really, could you explain.

Manager: Well . . . we've spent the last year or so trying to get a few more programs in [to the facility]. I think we've done well, considering all the obstacles . . . funding, participation, and the like. It's not easy to make a silk purse out of a sow's ear. Things are slow to materialize here. What we do have going for us now is the momentum of the four programs. People are now more interested in using them. At first, housing keeping was the first program, people were leery of getting help. I could think of four or five people who needed the help, but couldn't get them to bite. They did not want people in their apartment. Thought that I was somehow targeting them and that by accepting the program, they would be moved. That did happen, but not for those reasons. If anyone was moved, it was because that was what they needed at the time. Now, we have a better record of meeting the residents' needs.

Interviewer: What other types of programs would you like to get on-site?

Manager: At this point, I don't know where we would go from here. I think I've used up all my favors in getting these programs underway. I know that more will be needed, especially over the next five to ten years. There is just no way that we

> can keep people here with these few programs. This is just like trying to feed an elephant with breadcrumbs. There is so much more to do [continues to talk about possibilities].

Discussion

This manager has attempted to create a supportive environment for her seniors to age-in-place by creating a core of services most requested by tenants. These programs--primarily off-site services--have strengthen the supportive nature of this environment, but like all **reactive approaches**, only addresses needs after they have been presented in some manner. While it is unlikely that this housing project will ever approach the comprehensive and proactive nature of a Section 202, this manager has taken appropriate responses to support her needy elders.

By accessing and using the resources of the community, this manager has been able to better serve her population. One resident of this project states:

> Before Miss Annie [not her real name] became manager here, we did not have the help she gives us. What we like--and I can say we because not one soul thinks ill of her--what we like about her is that she takes the time to have a kind word with us. She has comes out to visit with us . . . and not just us [seniors] but all of us [residents]. She will keep an eye on us no matter what. (Resident 34)

It is clear that this manager--despite a **reactive approach** to aging-in-place--has more than simple "bricks and mortar" issues on her mind. The goal is to do as much as she can to keep her elders at home in their apartments.

> I know that their [seniors'] life was not, and is not easy now. I think the least I can do is try to make their lives a little bit better. If this helps than I can go home a bit happier. (Manager 16)

Neither a perfect supportive service situation, nor a complete aging-in-place option, she makes significant strides to create a minimally supportive environment with available community services.

Case Study 5: Proactive Approach

Manager 48 operates a Section 202 housing facility in north central Florida that has a large population and high concentration of elders with approximately 107 senior residents. This management team has worked to create a network of on-site and community-based services that are in place to support elders when they are in crisis. "We work not only to provide services, but anticipate need in our population." By approaching aging-in-place from this perspective, management and staff can be prepared for the supportive services direction the population is moving. An additional benefit of this site is the relationship that exists among service coordinator, management, and residents. By having the three "teams" working together in a coordinated effort, seniors maximize their benefit of services, environment, and health care in the residential environment.

Interviewer: What is your biggest asset to aging-in-place?

Manager: We approach it [aging-in-place] with a complete set of programs to support seniors in need. Through our service coordinator, we can check on residents and provide flexible service delivery of health services, transportation, meals, homemaker services, and personal services. What we want is to never be caught "flat footed." We want to have our services in place and ready when residents need them.

. . . . . .

Interviewer: What services are utilized most by your residents?

Manager: Probably homemaker or housekeeping services, them health services, and last . . . Oh, I guess transportation. Lots of residents like the bus. Though not perfect it does give a sense of freedom to many of our residents who can't drive. We usually try to get them to a restaurant two times a week. We go shopping once a week at a grocery store and every other week or so to Wal-mart, or someplace like that. Sometimes we plan fun trips for the residents. . . . The last trip was to a museum downtown.

. . . . . .

Interviewer: Can you give me an instance where your services helped keep someone at home?

Manager: There is one woman that is having a pretty tough time with her health. She has very bad heart problems, but she has been able to stay in her apartment. She has someone come in and help with cleaning, maybe two times a week. She has access to meals here in the dining room. If she is not well enough for that, we will take a meal to her.

Interviewer: How often are you willing to do that?

Manager: I think we take meals to her maybe six to ten times a month.

Interviewer: Up to one-third of the month? That doesn't pose a problems to your staff? Doesn't create resentment or bad situations with other residents?

Manager: Heavens no. Most people around here don't have time to worry about someone else's problems. Life is short, my boy. If you've got time to worry about someone else, you've got too much time on your hands. You need kids or something to worry about. We can take meals to residents, that's no problem. That's really what staff is here to do--help these people any way we can.

. . . . . .

Manager: [Getting back to the resident's story] She also keeps an eye on her health with our visiting doctor and nurse program. I think that has *really* helped her. She was visiting the hospital . . . oh, may four to five times a year . . . now she is better in tune with her needs and has only been twice this year. I really think the regular visits [by the doctor] are helping.

Interviewer: What if these programs were not in place? Do you think you could create them "out of the blue" to respond to residents' needs? Would this resident still be here?

Manager: I don't think we could support our seniors as well as we do without being prepared. To try to create programs, by the seat of our pants, is not something I would want to do. I think this is much better. Trying to anticipate need and be ready is what we should be in the business of doing. It makes them [elder residents] feel more at ease when the service coordinator or I say this is what we are going to do. It makes us sound prepared . . . knowledgeable . . . we are prepared and they [the seniors] know it.

. . . . . .

Manager: To answer your last question, no she [the resident discussed in this interview] would not be here. I didn't go into all her details but suffice it to say she probably would have been transferred if we were not as prepared. You may not realize it . . . maybe you do . . . how many interviews have your done?

Interviewer: I've done 47 other interviews before this one.

Manager: Maybe you do understand. It's tough to try to keep all these people going . . . and going . . . you know like the Energizer bunny. Even with a service coordinator it still isn't easy. These people deserve so much better than they get. If you've been to other housing [sites] you know what some of them are living in.

Interviewer: What do you think about aging-in-place issues in other types of facilities?

Manager: I think it would be tough to do. I don't want to say anything bad about the other administrators and managers out there. Most do everything they can for their seniors. Some places don't have it as good as I do. I know that. Some places aren't great places for seniors to try and live. It can be tough. I'm sure most of the managers try to do the best they can.

Interviewer: Would it surprise you that some facilities do nothing to help their elder residents?

Manager: No. But you mean places like Section 8s, right?

Interviewer: Mostly, but others [housing types] offer few, if any services.

Manager: [Interrupting.] Right, but you're missing the point . . . or maybe HUD is missing the point. Seniors really need places that are ready for them. They need more than a place to keep their medicine, or hang their hat. They need a place that is prepared to help them. The Section 8s that you are talking about are not bad places, don't confuse them with bad places. Those managers are trying to do the best they can with what they have to work with. I ran a Section 8 in Fort Lauderdale for four years and it's no piece of cake, believe me. You do what you can to help as many people as you can and not get buried under the paperwork. \

Discussion

Through the **proactive approach**, this site can maintain elders in their apartments through coordinated services, managerial concern, and resident participation. By encouraging residents to be accountable for their service needs, staff members can ensure satisfaction of long-term care needs, as well as quality of life. Residents are no longer reticent to bring their needs to management or the service coordinator for fear of being "moved out" or relocated to a nursing home. In this way, residents become accountable in a way they could never be under the **inactive** and **reactive approaches**.

The manager also believes that dealing with problems in this way gives her more time to focus attention on other issues, including "bricks and mortar" concerns to make the physical components to the housing project better, safer, and more reliable. "I don't have to worry that by focusing attention on my residents that the building is in some way being neglected. That's makes everyone happier . . . especially me" (Manager 48).

Lastly, the manager is better able to interface with her residents because they know that she is not out to relocate them. "I know that I can have genuine conversations with my folks because they are not afraid of me or my staff. I learn what's *really* going on in their lives--both the good and the bad" (Manager 48). Having this kind of relationship with residents not means genuine knowledge of people's lives, but allows her to speak to them as someone who is really concerned with their lives, well being, and health. "I know that when I talk to my folks, they know that I am really concerned about them. Even if the news is not always good, they know that I have their best interests at heart" (Manager 48). The **proactive approach** brings managers out of their office and into residents' lives by making them more accessible to management's concern.

Case Study 6: Proactive Approach

Manager 23 operates a Section 202 housing facility in north Florida that has a large population and high concentration of elders. Currently, the population is around 123 elder residents. Many of them are active, though according to the service coordinator, about 70% of the population relies on one or more supportive services available through on-site or community-based services. The manager works hard to keep elders in their homes by creating strong connections with tenants through the service

coordinator. Both work together closely to ensure each resident is receiving appropriate attention and service.

Interviewer: What does aging-in-place mean to you?

Manager: Aging-in-place is keeping our residents in their homes. Most of the issues that center on aging-in-place are dealt with by our service coordinator. She works to make sure residents have the services they need, but also tries to anticipate their needs for the future. I don't want us to be caught "flat footed" so to speak. My management style to avoid surprises.

Interviewer: Why is that important?

Manager: What we want to do is try to know where our residents are going . . . in terms of need. We want to try to be prepared for them when they need a particular service. Hold on a minute and let me see if our service coordinator can come in.

[Contacts service coordinator.]

Manager: [Continuing] We want to create a trusting environment where the residents can come talk to me about what's going on in their lives. It is important to me for them to know they can talk to me about their problems . . . or the good things, too.

[Manager pauses, waiting for the service coordinator to come into the office.]

. . . . . .

Manager: Mike was just asking about our programs to keep our residents in their apartments and I thought you should be in on this conversation.

. . . . . .

Interviewer: I asked Sue [not the manager's real name] about what aging-in-place means to her. What does that term mean to you?

Service Coordinator: Well, I think that defines the kind of work we should be doing as a housing community. We need to focus on those issues and services that keep residents in their homes, keep them healthy, and give them the kind of freedom they need to live their lives. One of the things we tend to forget is that these people have their own lives. We want to try and help them, but we do not want to become so overbearing . . . telling them what to do or how to live that we change their lives in some way.

Interviewer: So you are placing the emphasis on autonomy, dignity, and the like.

Service Coordinator: Yes, we just aren't running an adult day care here. These people are . . . or should be . . . living their lives. All of their decisions should not be left to us, otherwise we're running some sort of gigantic nursing home.

Manager: We want to run a housing complex that is a community, that has services that help people, that has services that keeps people here, but not one that changes them into something that is manageable. I'm sure you heard other managers talk about services changing the facility . . . well we don't want to do that at the other extreme.

Interviewer: You've given me a lot of good information, but do you have any specific examples that you can share with me? An instance where this has all come together in the right way?

Manager: This one is yours, Lisa.

Service Coordinator: One of the female residents--Annie [not her real name] has been here . . . oh, maybe three or four years. I think she is in her late seventies. Within the last year she has had some health problems and has slowed down a lot. I mean she went from walking . . . being active in the complex here . . . you know, helping out in the recreation room, making trips to the book mobile for others, a lot of good work. She started having trouble. At first she was very hesitant to having anyone help her . . . she got very adamant about not getting too much help. She wanted to make sure that she could still do for herself. I spent a lot of time with her. Making sure that we weren't neglecting her, but also making sure that she had the independence she needed to work through this. I really believe that by making sure she could deal with this, she became more accepting of the services as I brought them in. Oh yeah, it took about a month . . . maybe six weeks to get her into a routine, but I think this was the best way to do it. She needed to realize that she still has a lot to contribute to the complex. Now she gets out when she can, but doesn't feel like she is at the "services'" beck and call. You know.

Interviewer: So even though you knew she needed services, you let her come to accept them on her own terms? You let her adapt to them and what they could do for her?

Service Coordinator: I had the leisure to do that. It took a lot out of my day to spend that month with her, but I think it helped her to adjust to all of the problems she had to confront over the time she lost her drive and mobility.

Interviewer: Do you think she is better adjusted than some of the others who just had services come in?

Service Coordinator: Like I said, this is what's better for Annie. It all goes back to the decision to leave some of the thinking . . . some of the independence up to the residents. I would have preferred to do it differently, but this isn't my life. It's Annie's. She is the one who ultimately has to be satisfied and happy.

. . . . . .

> **Manager**: I think giving them [residents] back some of their autonomy is one of the best things we can do for them. I'm willing to bet you that's something that doesn't happen too often for a lot of people out there. It's something to think about as you go back to your university to write up the results. For this group of people, they are missing so much. This seems like the least we can offer them--a little bit of dignity in their old age.

Discussion

Like the previous case study, this one emphasizes the benefits of the **proactive approach** in supporting elders to age-in-place. Additionally, this manager and service coordinator place significant importance on elders maintaining "independence, autonomy, and dignity" by keeping them involved in the decision-making processes to secure services and maintain residence in the project.

> **Service Coordinator**: We encourage our residents to take some of the responsibility in their own care, that way we [can] keep them involved. This gives them a sense of individuality, keeping them involved in important day-to-day events. Also they have a say if they don't want something done or having someone come into their homes. Really, this gives them choice. (Service Coordinator 1)

This not only keeps residents and managers (or their designates) in frequent communication, but decreases the likelihood of having "surprise" crises arising.

As this case study makes clear, there has to be more to aging-in-place than supportive services. Residents have to be involved in their own care, long-term or otherwise. Ultimately, the role of supportive services is to maintain independence not take it away. Too many times, elders are forced into care "for their own best interests" or "for their own good" without really asking the seniors themselves for an opinion. This management team tries to provide support, but leaves final decision to elder in need.

> **Manager**: Ultimately we know that whatever decision the resident makes is his decision. We know that *they* are in control of their lives, right or wrong, good or

bad. We have provided them with a supportive environment that *they* can live their lives. (Manager 23)

Summary

The different types of low-income, subsidized housing offered varying supports for aging-in-place across a broad spectrum of possibilities. Most managers were supportive of their residents to aging-in-place, even if that support was limited to words of encouragement or the tenuous provision of services. They worked within the guidelines of their facilities and the supportive services that were immediately available. Those managers that did not support this principle, most often managed facilities that had few, or very few, elders with little likelihood of gaining community support for services. The three approaches to managerial aging-in-place link very closely to the type of facility, size of the population, and concentration of the elder tenants. Managers who applied the **inactive approach** to their facilities created environments that had no concern for their residents, their needs, or their long-term occupancy of apartment units. These highly unsupportive facilities had very few long-term elder residents. On the other hand, managers who engaged the **reactive** and **proactive approaches** to aging-in-place had much better success at retaining and maintaining long-term elder populations. While the **reactive approach** only demonstrated limited success, the **proactive approach** offered highly supportive environments with many frail, though independent residents.

The interviews presented here as case studies and the other 105 resident, 42 manager interviews, and one service coordinator that comprise the research, highlight the role of the managerial perspective in creating supportive environments to age-in-place. Managers and residents approach this issues from opposite ends of the spectrum. Managers seek to limit "triggering" mechanisms in residents; in effect hoping they will

not exhibit "signs" of needing to be moved to a new residential environment. Residents, on the other hand, views services as the best means at judging whether they can remain in their apartments. The success of aging-in-place programs is tied to the ability of the environment to limit frailty by providing services to support elders in their day-to-day activities.

Solutions in Lived Experiences

To attempt to understand aging-in-place without examining the relationship between the environment and the individual overlooks the dynamic set of relationships that exist in a government subsidized, low-income housing environment. The factors at work in constructing the long-term occupancy of any subsidized housing project are the result of the inter-locking relationship between housing type, the manager's approach to aging-in-place, and the supportive service needs of the resident. More importantly, however, providing services without encouraging and maintaining resident autonomy, dignity, and independence is a waste of time. Residents need a supportive environment that allows them to dictate their own conditions of support. Of the three models to aging-in-place models profiled in this chapter, only the **proactive approach** allows residents enough "room" to make those kinds of decisions.

The three approaches to managerial aging-in-place discussed in this chapter serve to illustrate how Florida's low-income, government-subsidized housing managers and their frail residents express issues of aging-in-place in the context of environmental congruence. Without the congruent environment, neither manager nor resident can hope for long-term residency.

CHAPTER 6
SUPPORTIVE SERVICE ECONOMIES OF SCOPE AND SCALE IN FLORIDA'S LOW-INCOME, SUBSIDIZED HOUSING

> The recently published article by Gonzales (1997) in *Health Services Research* asserts that there is empirical evidence in support of the existence of economies of scope in home healthcare. This conclusion differs markedly from that found in an earlier study that concluded that neither economies of scale nor economies of scope are substantial in the provision of home health services.
>
> David I. Kass (1998)
> *Health Services Research*, vol. 33, p. 947

> Goods and services can often be produced at lower average cost when they are produced in larger quantities.
>
> Barney Warf and J. W. Harrington (1995)
> *Industrial Location: Principles, Practice & Policy*

> As the size of plant and the scale of operation become larger, considering expansion from the smallest possible plant, certain economies of scale are usually realized. That is, after adjusting *all* inputs optimally, the unit cost of production can be reduced by increasing the size of the plant.
>
> J. Gould & C. Ferguson (1980)
> *Microeconomic Theory*

What Are Economies of Scale and Scope? Why Are They Important?

This chapter reports on an investigation of how economies of scope and scale influence the supportive service economies of Florida's government-subsidized housing projects. These manifestations of scope and scale allow service providers and project managers to supply low-cost, high quality services to needy, frail populations. As an additional benefit of scope, managers can provide a greater complement of services as

on-site support for elders. Care and support of frail elders imposes a considerable financial responsibility--and potential burden--on families, communities, and the nation. In particular, the state of Florida must confront the issues of long-term care and supportive services in order to secure its economic future and establish a benchmark for quality aging-in-place programs. Currently, Florida's government-subsidized housing projects can benefit from two strategies by which to deliver supportive services to frail tenants. The first, *economies of scale*, deals with an on-site or community-based provider's ability to offer one specific service to a large group of elder consumers at a relatively low cost. In the case of Florida's government-subsidized housing, this is often done by an off-site service provider, though some facilities, with large enough populations, are able to assume this responsibility in-house. Because of service specialization, a provider is able to serve a large population, while maintaining lower delivery costs when compared to deliveries of the same service to a geographically dispersed population at-large. In turn, this reduction in cost translates into a greater savings to the resident using the service. A facility that takes advantage of economies of scale--with respect to its service provision--has the ability to offer low-cost services crucial to this population's aging-in-place.

The second economic option, *economies of scope*, deals with a project's ability to provide multiple services from a single human services provider, or multiple services to an on-site senior consumers' group plus a nearby population in a proximate neighborhood. A facility that enjoys economies of scope with respect to its service provision is able to harness its staff, knowledge, and other site-related resources to provide two, three, four, or more services to residents as on-site services. By maximizing

available resources at one location, the housing project is better able to offer reduced prices to residents on core services, and at the same time assist senior residents to age-in-place.

Economies of Scale

The term *economies of scale* embraces a variety of relationships between the unit costs of the service and the size of the population utilizing the service. In studying this concept, three results are possible in the supportive services realm. These "ideal" representations are illustrated below (Figure 6.1): economies of scale (A), a reduction in unit cost the more units are produced; diseconomies of scale (B), an increase in cost the more units are produced; and constant returns to scale (C), a leveling of costs, no matter how many units are produced. Each of these economic "possibilities" plays a key role in the four economic models found in Florida's government-subsidized housing projects.

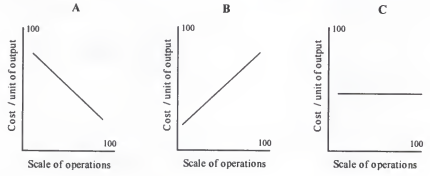


Figure 6.1. Graphs of Economies of Scale.

In principle, capital (in its variety of forms) can be subdivided as finely as desired, but that cannot be said for other resources like people, tools, or knowledge. As a consequence, these resources can only be used efficiently when the scale of activity is large enough to employ them fully. Furthermore, those resources that are divisible generally cost more per unit in small amounts. This is important when comparing the

provision of services to two, three or four members of a project versus forty, forty-five or fifty. Costs for service delivery are considerably more expensive to a smaller group of senior consumers. Since these costs can be reduced by operating on a larger scale, a scale economy is involved; thus, creating advantages in serving larger populations.

> **Service Provider**: [With economies of scale] most [housing projects], if they know what they're doing, should be able to reduce costs by ten, fifteen, twenty percent . . . depending on the[ir] population served. By focusing on that one service--and having a large enough population--they gotta be able to make money, service their [population], and do what they need to get done. (Service Provider 1)

Costs can be reduced further by a finer subdivision of tasks, permitting even more specialization of service-related tasks to occur. For example, staff members can be highly trained to provide one type of service, or one particular aspect of a service. There is one caveat for this type of integrative economy, illustrated in (B) of Figure 6.1. Though economies of scale are associated with large numbers--like the service network supplying large numbers of elders in a Section 202 housing facility--as size increases, other costs may eventually rise to the point where they outrun the economies of the source. For example, diseconomies of scale are created where costs begin to rise as the number of services supplied increases. According to Kass (1987 & 1998), this can be a very real concern for home healthcare providers because certain sectors of the industry can prove to be so expensive that internal costs outpace what clients are willing to pay for those services. For that reason, Kass (1998) cautions about making overly optimistic assessments of service delivery economies of scale. Some community-based service providers, and on-site providers as well, face diseconomies of scale as they attempt to provider ever-greater numbers of supportive services to the residents in a particular project or geographic area.

> **Service Provider**: There was one home health provider that expanded too quickly into the Tampa area and costs got too expensive. When they tried to pull back, it was too late. Even though they had customers, they could not make the bottom line. They went out of business leaving a hole in the south side. (Service Provider 1)

This obstacle has forced some human service providers out of a geographic area, leaving elders to secure services for themselves.

Economies of Scope

The second strategy, economies of scope, relies on the ability of one housing project or service provider, to supply a variety of services in an efficient and timely manner to a targeted group of elder consumers. In contrast to economies of scale that focus on a specific service offered to a large population, economies of scope brings multiple, low-cost services to a project's population. In principle this economic flexibility hinges upon moving beyond the traditional notions of economics:

> . . . Fordist priority [of] mass production based on economies of scale [giving] way to economies of scope, cost savings based on producing a variety of products or services in small--even one of a kind--batches. Ideally, such a factory 'can produce a continuous stream of different product designs at the same cost as an equal stream of identical products.' (Malecki 1991, p. 236)

For on-site service providers, this means allocating available and unused resources to perform additional jobs and services for tenants.

> **Service Provider**: This is where my company makes its money . . . but [housing projects] are doing it, too. Using [existing] staff and targeting the right services, [housing projects] can supply the three to five services most in demand. (Service Provider 1)

Thus a single employee may have multiple job responsibilities such as providing housekeeping services, running errands, and providing transportation. In economic terms, this may include a variety of processes to address the service needs of the housing project: (1) adapting, installing, and utilizing assistive technology for bathing, toileting,

and ambulating in apartment units with maintenance staff, (2) satisfying service demands for housekeeping, errand, and homemaker services with on-site service coordinators, (3) adapting to the difficulties in planning and scheduling on-site services to mesh with schedules, and (4) a dynamic situation of implementation and control over supportive services to meet the needs of the "new" clients accessing services for the first time,

The Cost of Providing Care

As the state of Florida confronts the issues of long-term care, they are faced with an ever-growing demand for supportive services and diminishing resources to meet that demand. The state must find feasible alternatives to expand its housing and services choices while containing costs.

> Approximately 15 percent of the noninstitutionalized population that is limited in activity due to chronic conditions make about 30 percent of the visits to physicians and account for approximately 40 percent of hospitalizations. Persons with activity limitations make twice as many physician visits per person than persons with no activity limitations. (Cluff 1996, p. 111)

Medicare, which often supports the medical needs for this population, has used a standard of "medical necessity" to judge the placement, advocacy, financing, and use of assistive technology that can reduce the occurrence of life-threatening and independence-limiting events. The federal government has an interest in addressing supportive service and assistive technology issues in subsidized housing that enable safer and more independent living, improving health and well-being of the frail elders, and reducing the financial burden that results from costly medical care and premature institutionalization.

The motivations to provide supportive services to elders in government-subsidized housing, and keep them independent and in their own homes, comes from the enormous burden on fiscal resources if seniors are prematurely institutionalized at the

government's expense. Expenditures from Medicaid for nursing home care are increasing and creating oppressive financial problems for state and federal governments. Current discussions regarding national health care reform, including proposals to increase home care and supportive services, might reduce the need for nursing homes, especially in this population subgroup. Though literature on this topic is conflicting, home-necessary health care and personal care delivery services to buildings occupied by seniors, likely, helps reduce the cost of care to this population. Despite this reduction in cost, other complications are predicted.

> But this could cause a rise in the severity of illness and disability found in the population remaining in nursing homes, further exacerbating the cost and complexity of nursing home care. It is uncertain whether or not provision of more . . . [home based care and supportive services] . . . would be more cost effective. If home care services are expanded [into government subsidized housing projects] it will be necessary to ensure that [providers] have the skills to use long-term care. . . . (Cluff 1996, p. 112)

Despite the obvious costs of long-term care, continued development of supportive service networks and the creation of economies of scale and scope within those networks contribute to improving people's lives, quality of life, and well-being that restores independence to the service dependent frail elders of low-income, government-subsidized housing. By putting these service networks into place, managers and residents can take advantage of lower operating costs and a wider variety of on-site and community-based services to support aging-in-place. More importantly, however, these economies of scale and scope will improve the quality of supportive services and reduce their costs to the frail elders who depend on them.

The Function of Economies of Scope and Scale in Florida's Government-Subsidized Housing: Four Service Delivery Models

Economies of scope and scale in Florida's government-subsidized housing will likely play a greater role in keeping frail elders in their homes in the 21st century. Though health care and service providers agree that the most critical component of any service delivery approach is service coordination (Golant 1999), elders and managers must also agree on the particulars of service provision. The ultimate feasibility of any form of service agreement relies on the cost-effective and fiscally efficient construction of on-site and community-based service networks. Without these types of services, residents risk one of two ultimate outcomes--service inaccessibility and its concomitant threat to their physical and emotional quality of life or premature institutionalization in a nursing home.

The four models of service delivery detailed in this chapter highlight specific avenues of connection between frail elders, management, and supportive service provision at both on-site and community-based locations. These models not only demonstrate the programs in place, but the possibilities that exist in the housing projects across the state, taking into account local infrastructure and levels of resources. These four approaches each offer varying opportunities to deliver cost-effective services to elder tenants in government-subsidized housing.

The first, **service inactivity**, offers no significant economies of scope or scale. Typically this form of integration is found in small population/low density housing projects that offer no supportive services--either through on-site venues or local community contracts. Second, **community-based service activity**, takes advantage of economies of scale to maximize a particular low-cost service to a larger population/

higher density of elders residing in government-subsidized housing, usually through local contracts. It can also benefit smaller population/lower density housing projects. Third, **on-site service activity** takes advantage of economies of scope as on-site providers attempt to maximize the number of services offered by staff members. This type of service economy is often encountered in larger population/higher density housing projects that offer on-site service with no or few community-based service ties. In some facilities, this is the building block to the last of the three economic integration formats. As projects become more successful at developing community ties, raising money for needed programs through grants and other sources, and strengthening relationships with needy residents, management can better and more easily evolve into the fourth form. The fourth integration model, **on-site and community-based service activity,** creates financial and service benefits from both on-site and community-based resources. The fourth service strategy is often found in Section 202 housing facilities, and other projects with larger populations/higher concentration of elders. By providing a variety of services, these housing types offer the most secure environment to age-in-place and support frail elders in their desire to remain independent.

Each of these four integrative methods provides for scope and/or scale benefits or disbenefits in the provision, access, cost and utilization of services, depending on the type of project and number of frail elders in the project's population. Any facility offering the most minimal of services has a distinct and clear advantage in fostering aging-in-place over projects that have no on-site supports or contracts with local providers.

Service Inactivity

The **service inactivity** model encompasses facilities that do not have supportive services present on-site or through contracted providers (Figure 6.2). For these

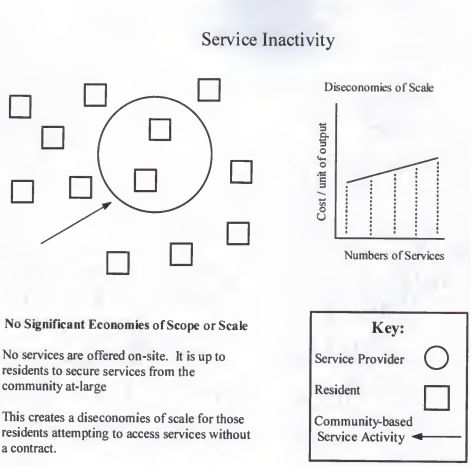

Service Inactivity
Diseconomies of Scale
Cost / unit of output
Numbers of Services
No Significant Economies of Scope or Scale
No services are offered on-site. It is up to residents to secure services from the community at-large
This creates a diseconomies of scale for those residents attempting to access services without a contract.
Key:
Service Provider
Resident
Community-based Service Activity

Figure 6.2. Service Inactivity Model

managers, this allows smaller population/lower concentrations of elder tenants to access services without having management bear the responsibility for maintaining a service network, employees, or oversight of elder tenants. Without on-site supportive services, frail tenants must seek assistance from more expensive, non-contracted providers or deal themselves with state-subsidized services and confront the usual bureaucracies and administrative difficulties of the system, if at all. This means that elders are less likely to have a sufficient knowledge base to address future supportive service needs.

Without on-site support, many elders feel vulnerable and isolated. They have both less ability and confidence in making wise supportive service decisions. This is

compounded for those with no family or friends to discuss assistive and long-term care options. Additionally, this group is likely to make less optimistic health and frailty assessments in their own health and well being regarding long-term occupancy of their apartment.

Without the price advantages of on-site services, many elders are confronted with diseconomies of scale paying for needed services. Rates for non-contracted providers tended to range from ten to fifteen percent higher than comparable contracted or on-site services. Though some literature suggests that economies and diseconomies of scale are not substantial to the overall market costs of home healthcare services nationwide (Kass 1987, Hay & Mandes 1984, Kurowski et al. 1979), others disagree (Gonazales 1997). Most government subsidized housing managers have no comment either way. Currently, there are no conclusive studies addressing these issues. In the case of Florida's subsidized housing of frail elder tenants, these increased costs do not improve the likelihood of these housing types encouraging age-in-place or having managers judge their tenants' frailty more optimistically.

Community-Based Service Activity

The **community-based service activity** model encompasses facilities that do not provide services on-site, but have contracts with service providers in the community at-large (Figure 6.3). Many managers choose to initiate service contracts with off-site providers to guarantee their residents reduced prices, or a certain level of service access. These managers realize the important role supportive services play in keeping elders in their homes, even if they do not have the population or concentration to reasonably provide services on-site.

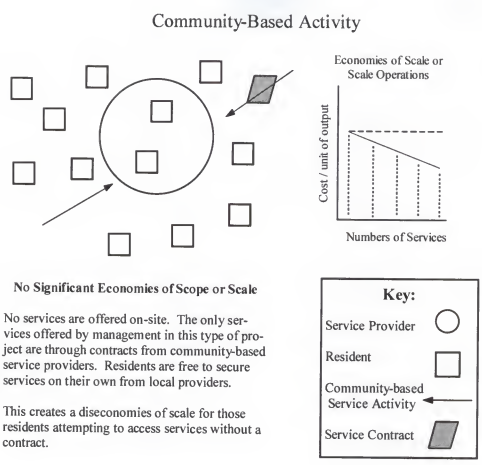

Community-Based Activity
Economies of Scale or Scale Operations
Cost / unit of output
Numbers of Services
No Significant Economies of Scope or Scale
No services are offered on-site. The only services offered by management in this type of project are through contracts from community-based service providers. Residents are free to secure services on their own from local providers.
This creates a diseconomies of scale for those residents attempting to access services without a contract.
Key:
Service Provider
Resident
Community-based Service Activity
Service Contract

Figure 6.3. Community-Based Activity Model.

Realizing the key role services play in aging-in-place, these managers attempt to overcome some of the drawbacks of diseconomies of scale at the root of the service inactivity model, but still fall short in completely eliminating them. If the service complement of the community-based service contract does not address the needs of the frail residents, they are still faced with the possibility of considerably higher costs when they leave the supportive service contractual "network" to address highly individualized service requirements. Alternatively, they must deal with the bureaucracy of service delivery programs subsidized by state of Florida.

This economic model will occupy a key position in the future as many of the small population/low concentration housing developments' begin to include more elder tenants. When this occurs, managers have greater incentive to "search out" supportive service opportunities within the local community.

On-Site Service Activity

The **on-site service activity** model encompasses facilities that provide supportive services on-site (Figure 6.3) to their frail elder tenants. Usually, these services are targeted to the specific needs of the elder tenant population. Because of the cost advantages, residents have strong financial incentives to use these services. By providing on-site supportive services, managers address the core needs of their frail tenant population with low-cost service for aging-in-place. These on-site services can have several important influences. First, managers have a mechanism for monitoring frail tenants, ensuring adequate service utilization and access. This prevents "crisis situations" from developing into relocation scenarios. Second, frail tenants have a more realistic appraisal of their needs to maintain independence because supportive services help them to benchmark their abilities against expected activities. Third, managers are far less likely to judge elders frail when tenants receive services in a monitored residential environment. Together, these three factors increase the likelihood of aging-in-place outcomes and at the very least ensure elder residents have a voice in improving their quality of life.

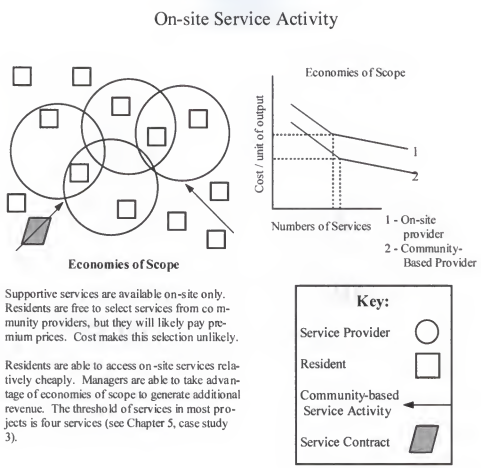

On-site Service Activity
Economies of Scope
Cost / unit of output
1
2
Numbers of Services
1 - On-site provider
2 - Community-Based Provider
Economies of Scope
Supportive services are available on-site only. Residents are free to select services from co m-munity providers, but they will likely pay pre-mium prices. Cost makes this selection unlikely.
Residents are able to access on-site services rela-tively cheaply. Managers are able to take advan-tage of economies of scope to generate additional revenue. The threshold of services in most pro-jects is four services (see Chapter 5, case study 3).
Key:
Service Provider
Resident
Community-based Service Activity
Service Contract

Figure 6.4. On-Site Service Activity Model.

The majority of managers offering on-site services work to maximize the advantages of economies of scope. They focus on addressing the comprehensive service delivery needs of a more frail elder resident population in the residential environment indicates that as scope of services increases, most facilities experience a decrease in service costs (Gonzales 1997). Research by Gonzales (1997), Kass (1998 & 1987) have contributed to other significant findings on this topic. The most revealing is that economies of scope are not necessarily present in all areas of supportive service provision, and some diseconomies may exist (Gonzales 1997, Kass 1998 & 1987). With the increasing nature of competition among home health providers (under contract to projects or as fee for

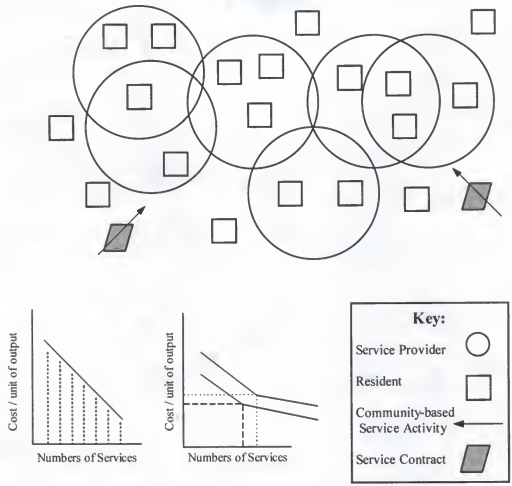
service) economies of scope and scale become crucial in the efficient delivery of assistive services and the profitability of those services. By taking advantage of resources already in place like employees, equipment, and skills, housing project have the ability to provide "extra" services with very little additional overhead expenses. Other benefits are equally important:

> With increasing emphasis on home health as a less costly healthcare alternative, utilizations of home health services has increased. . . . Given recent business trends in this industry and the increasingly competitive nature of the environment, cost and efficiency are important considerations in management decisions. (Gonzales 1997, p. 314)

Due to the nature of scope economies, many of the government-subsidized housing projects in this study have upper limits as to the number of services they are able to provide. For most facilities, four services is this upper limit; but one well-connected manager has been able to generate a fifth on-site service from broad services like transportation, health screenings, nutrition programs, and home maker services (see case study 3 in this chapter). This has proven to be highly unusual among the 48 sites visited. From a competitive position--or perhaps a customer satisfaction position--the addition of this service has proven beneficial to the residents and financially valuable for the project. The success of such ventures of "pushing the supportive service envelope" depend greatly on three factors: location, facility type, and requirements of the tenant population.

On-Site and Community-Based Service Activity

The **on-site and community-based service activity** integration model draws upon advantages of both on-site and community based services (Figure 6.4) to provide assistance to frail, rent-subsidized elders. By drawing on both economies of scale to provide lower cost services and economies of scope to provide greater numbers of on-site



Economies of Scope and Scale

Supportive services are available from both on-site and community-based providers. Many off-site services are available through contractual arrangement with local service providers. Residents are still free to select services from a non-contractual provider on a fee for service basis. This model provides the most support for residents to age-in-place, maintain independence, and reduce the likelihood of being labeled frail by management.

Figure 6.5. On-Site and Community-Based Service Activity Model.

services, elders needing assistance not only have a wide variety of services to choose from, but benefit from the most cost-efficient ones to maintain independence and age-in-place.

This one is the most likely to be found in large homogeneous populations of seniors--especially housing projects like Section 202s and other residential environments

with larger populations and higher concentrations of elders. By combining the advantages of both economies of scope and scale, housing projects like Section 202s can provide the variety of services to support aging-in-place in cost-efficient manner.

Economies of Scope and Scale: Case Studies

Because many elders live in heterogeneous housing facilities--Section 221s, Section 8s, and Section 236s--instead of homogeneous Section 202s, these interviews document average events for managers in the variety of subsidized housing types. Generally, managers are going to have the greatest access to services in large, age-dense housing types, which provide both on-site and community-based access to supportive services.

Four brief case studies and excerpted sections of the selected interviews with varied groups of seniors and their managers will be presented in this chapter. These dialogs will offer greater understanding of the questions pertinent to economies of scope and scale for managers of low-income, government subsidized housing projects. The resident responses will address various questions: Do they take advantage of economies of scope and scale? What kinds of service networks to they create or have access to? Do they see themselves offering, getting, receiving more supportive services in the future? Do they see themselves as having a role in a service network or with a service provider? The following "stories" illustrate how managers and residents confront the issues of economies of scale and scope.

Case study 1 examines a Section 8 housing project that does not offer services on-site; residents must access their own services from the community. Case study 2 examines a Section 8 housing project that does not offer services on-site, but has service

contracts with community providers. Additionally, residents are able to secure services from other providers as well. Case study 3 examines a Section 221 facility that offers four key on-site services, though has no formal connections with community-based services. Residents, however, are free to access services from the community at-large. Lastly, case study 4 examines a Section 202 housing project that has both on-site and community-based services. Residents have a variety of services to choose from, including transportation, health care, housekeeping services, shopping and errand services, meals, and case management

Case Study 1: Service Inactivity

Manager 35 operates a Section 8 housing facility in Florida's panhandle that has a small population and low concentration of elders. Eleven out of about 60 residents are seniors. He provides no services to his elder tenants because "to live here means that you are independent," but he places no limits on their own initiatives to access services from the community. Currently, he has no contracts with local providers.

> **Interviewer**: Though you don't offer services, do you allow your residents to bring services on-site?
>
> **Manager**: Of course, we allow our residents to access services in the community . . . and they use can them as long as they don't change the facility. But we do not have a [contractual] agreement with any of them. Again, that is the nature of this [housing] project.
>
> **Interviewer**: You mean that as long as they don't change the independent atmosphere. How will you know?
>
> **Manager**: If they become too dependent, they will need help living here . . . not just doing some activities. Help . . . I don't mind, but when you need help to live here, that is not what we are about. . . .
>
> . . . . . .

Interviewer: I've been asking other managers about economies of scope and scale . . . that is, asking about providing numbers of services and getting reduced rates for residents. You don't have any economies of scope or scale going on here . . . are you aware of other facilities that use the numbers of their residents to get reduced rates on services?

Manager: I know that residents here pay a bit more than at other places. They don't get breaks like at Pine Tree Gardens [not the facility's real name], but they have a larger population. We only have a few--more like three--that bring services in. The last time I asked them, prices were five or ten more than what I know they get at other places.

Interviewer: Do you think you should try to create some sort of service network so that residents could get lower prices?

Manager: Like I told you, that's none of my problems. This [place] is independent. If they [residents] want services, they get [th]em. What they pay is not my bother.

Discussion

By not offering on-site services and no contractual arrangements with local providers, this manager limits his responsibilities to his residents, but also eliminates the prospect of creating any economies of scope. By not offering community-based services, this manager limits his prospects of creating any economies of scale. Both types of static integration bring advantages to these types of housing projects--each with unique characteristics. Overlooking these benefits could have significant ramifications in the near future. According to this manager, the service inactivity does not currently impact his project, nor does he believe future options of providing services may be limited because of this choice. Not bringing services in "from the outside" means that residents pay more for any services they wish to utilize or must depend on state-subsidized services; but more importantly, this "island of consumers" will be overlooked by service providers. Informal conversations with two local service providers indicate that Manager 35's housing complex is slowly "dropping off our radar because he keeps telling us not to

bother him about what we can do for him and his tenants" (Service Provider 1). By taking this perspective, the manager forces his residents to pay the highest prices or experience the greatest difficulties to access supportive services in their daily routines. This also creates a "service gap" that will place limits on what elders know and expect from services to support aging-in-place.

The service inactivity model of economy plays a key role in limiting the aging-in-place prospects of tenants, as well as increasing the likelihood of being labeled frail. By working and living in "service isolation" managers create an unfair and unrealistic environment for their frail, elder tenants to age.

Case Study 2: Community-Based Service Activity

Manager 19 operates a Section 8 housing facility that has a small population/low concentration of elderly tenants. He has only recently created service connections with community-base providers in the last six to eight months. Prior to that time, no service contract existed and elder tenants were forced to find services in the community at-large on their own. One community provider, currently under contract, offers services in four broad areas--meals, medical monitoring, housekeeping, and transportation. Both manager and residents are satisfied with the service variety and accessibility, indicating that no new services or contracts are needed in the immediate future.

> **Interviewer**: Bill [not his real name], what motivated you to finally secure off-site services?
>
> **Manager**: Well . . . more of the older residents were having troubles and the agencies [providers] had come around recently. I called and talked to them . . . they had prices that were cheaper than what some of the residents were paying. Besides, we [the facility] are getting more older people . . . in the past they just moved on. . . . But now . . . that I'm manager . . . I try to keep them around a little longer. You know . . . where can they go from here . . . especially this group. No money . . . some with no family or kids . . . there really isn't anyone. Usually I

would try to get them into Oakwood Arms [not the facility's real name] the senior place about four or five miles from here. That's hard though. . . .

Interviewer: What kinds of changes have you noticed with the addition of services?

Manager: We've added four services. Meals. They are one of the most important. Some of these people would not be eating, or eating garbage [not literally]. They just didn't know what a good meal is. Now they get at least one balanced meal. You know the three [sic] food groups. I think that is the most important service. We're helping about nine or ten here. Medical monitoring--checking blood pressure, making sure they take their pills, just keeping an eye on them--is used but it's not as big. Housekeeping--about eight, nine, ten, something like that--use it. This one makes a big difference to me. The earlier manager [before Bill] would get rid of older tenants because the apartments became shit holes. You know they [residents] would be tryin', but really when the crap piles up and the stink gets bad . . . what else can you do? I think this is a pretty good thing . . . they [seniors] can get some help around the house at low costs and the [providers] even do a little more to keep [tenants] goin'. Bus service . . . well that's a gold mine for this group--it's not just that these people can't drive, but lots of them can't pay for a car . . . you know? Almost all of the older tenants use the bus. It comes around twice a week and can be scheduled [in advance]. These services mean a lot to this little group. . . . I'm sure more people will take advantage of them in the future.

. . . . . .

Manager: The residents [that use these services] have been up and around more. Some have started socializing more . . . they're outside of their apartments.

Interviewer: So these services have really made a difference?

Manager: I think so. I mean . . . really. It gives them some help they wouldn't have. It makes their lives easier. With the help, they know they'll stay here longer. Not forever, but longer.

Interviewer: Is it something that other projects--like yours--should consider? Is that possible?

Manager: Oh yeah. I think other places, like us, could do this. But affordability is the key. I mean it really depends on the services available in the area, but, yeah, it something that could be done.

. . . . . .

Interviewer: What's your next step? Will you try to do more [to help frail seniors]? Will you move to on-site services? Do you have something else in mind?

> **Manager**: I don't really see anything else, right now. There aren't enough people for us to bring services on-site. There are a lot of things keeping us where we are now. But this is okay. I don't think we need to offer any more services right now. These [services] are small steps, but they are good for us.

Discussion

By taking this first step to facilitate aging-in-place, this manager assumes more responsibilities for his frail, elder tenants. This manager is aware of the shifting demographics--"Besides, we [the facility] are getting more older people . . . in the past they just moved on. . . ."--and the role his housing project will play in housing frail elders in the future. He not only has concerns for elder tenants' continued residency in the housing project, but a concern for the prices elder tenants are paying for supportive services.

By offering community-based services, this manager is able to take advantage of economies of scope to reduce service costs. "By getting contracts [with service providers], I've been able to reduce costs for my tenants by ten to fifteen percent on most services . . . and up to twenty percent on one or two specific services" (Manager 19). This translates into residents being able to remain in their apartment units for longer periods without fear of being evicted for "breaking rules" or requiring service assistance. More importantly, however, this manager highlights the importance of the changing focus of small population/low density housing projects--to become part of the solution, managers must change their view of frail tenants and supportive services. He has made a change in the lives of his elderly tenants by including affordable services as a key component of the overall housing environment.

Case Study 3: On-Site Service Activity

Manager 4 operates a Section 221 housing facility that has a small population and low concentration of 16 to 20 elderly tenants. She has spent the last two years of her tenure as manager developing and improving links with the community, but has not yet succeeded in developing strong off-site service networks that are affordable to her residents and reliable. Currently, she is able to offer four key areas of on-site supportive services--transportation, health screenings, nutrition program, and homemaker service--but hopes to expand to both on and off-site services within the next six months to a year. These services are supported through community grants with residents paying fees based on their income, or a "fixed cost" for the service.

These services are supported by a variety of shared and on-site personnel. A part-time nurse--a position that is shared with three other nearby housing projects--provides the health screenings and counseling for the nutrition program. She visits the site eight hours per week. Similarly, the homemaker services are shared among the same four housing projects with six to eight hours allocated to this complex. Two "front office" workers drive the van three times per week to assist residents with shopping, doctor's visits, and other errands.

> **Interviewer**: Right now, you offer four services. Do you have plans of adding more in the future?
>
> **Manager**: That will probably be our limit. . . . Primarily because of costs, we will stick with just four.
>
> . . . . . .
>
> **Interviewer**: Do you make money off those four services?
>
> **Manager**: If we didn't, do you think we'd still have them? We generate enough money to keep the services sustained. Beyond that, I'm not going to talk about money.

. . . . . .

Interviewer: How significant is that money in making decisions about providing future services?

Manager: We aren't going to discuss money, what we do with it, or how much more can be made. Let's just say that four services will be all there will be.

Interviewer: Does the profitability of this package [of services] affect your decision to provide others?

Manager: Money is always a factor, but there is a lot more to it.

Interviewer: Like what? Can you explain further?

Manager: We aren't going to get into it. Four will be all we will provide for now.

. . . . . .

Interviewer: Do you have plans to involve community-based services? How soon?

Manager: Right now, there are no reliable services to bring on-site.

Interviewer: [Interrupting.] There are no dependable services in this area?

Manager: Reliable, affordable, available. At some level, each of those words has applicability. Some services are not reliable . . . in that they will not always be here when needed . . . or scheduled. Some services are just not affordable to us or the residents. I know of two instances where costs just got out of control for residents here and at Stoneybrook [not the facility's real name]. I'm not going to let that happen again. In some cases, there just aren't the types of services available. That was the primary motivation of starting them on-site. Slowly, we started with two major services, then three. Now we are up to four and that seems like a good stopping point.

Interviewer: I've noticed with some of the other sites that provide services that four is the magic number. Do you have any reason why that is the cutoff number?

Manager: That is a pretty typical number . . . for a number of reasons. First, it depends on the number of staff working at the site. Here we have enough people hired on to take care of some of those extra hours. . . . [Second,] some of those services can be overlapped with other residents' needs so that we can serve many residents during one hour. [Lastly,] the services we provide are the core services needed by our types of residents.

Discussion

This facility, and others like it, works to develop economies of scope through on-site service activity. In contrast to case study one and its service inactivity, this manager works to puts all of its service-oriented resources (employees, shared knowledge, and other available resources) to work in the delivery of multiple supportive services at its facility. This approach offers several distinct advantages over the service inactivity of the previous case study. First, residents have access to a reliable and cost-efficient core of services. Second, residents have a knowledge base about available products, know people who use them, and have a frame of reference for maintaining, altering, and transferring them as needed. Thirdly, residents have a support network that works with them to maintain independence, as well as a moderately knowledgeable staff that understands come of the components and necessities of aging-in-place for frail elders.

This manager is amassing her resources to move out of this level of economic service activity and into the next one--on-site and community-based service activity. She has built an internal service network and is working to incorporate off-site services into the project. This type of advancement becomes critical as she works to provide a more stable housing environment that allows her frail elders to age-in-place.

Case Study 4: On-Site and Community Service Activity

Manager 48 operates a Section 202 housing facility that has a large population and high concentration of elders with approximately 107 senior residents. This manager and her staff--including a service coordinator--have worked to create a strong, reliable, and low-cost network of on-site and community-based services to meet the needs of the facility's frail seniors.

Interviewer: You have a very well established service network. What sorts of advantages does that bring you and your residents?

Manager: I think the biggest advantage is the number of services that we can provide. We have mission critical services on-site. That means that residents can setup and access these services in less that two hours. If a resident suddenly needs services because of a medical or health problem, we can be there for them. Other services are brought in off-site by ImmediAide [not the company's real name]. It takes a bit longer to get people into their system. We have been pleased with them. They consistently demonstrate good service to us and the residents.

. . . . . .

Manager: For our residents, the network means lower cost services. Typically, the network saves residents ten to fifteen percent on services brought in and about twelve to fifteen percent on in-house services. That can mean a significant amount to these residents . . . perhaps extra groceries, prescriptions, or a doctor's visit at the clinic. That is a real life difference.

Interviewer: How practical--from a financial perspective--are these services to you?

Manager: Well, we do make a profit on some of the services. Some services we break even. Maybe a few we lose money.

Interviewer: [Interrupting.] Ultimately, you have to turn a profit, right?

Manager: Yes. Early on . . . we had grants supporting much of the in-house services. As time went on and we began establishing the network, then things became more profit oriented. But that is not a bad thing. By making money at the service program, we were better able to provide more services. You want to be cautious about making too many assumptions about these services . . . not just ours. It is important to know where the funding is coming from. Some programs don't have to make profits because they are funded through other sources. Still others are community-based non-profit projects that are funded through donations . . . those don't get profits either. Others, like ours, has a profit motive that gives an incentive to make money.

Interviewer: [Interrupting.] You make money or the services are gone, right?

Manager: For this program, yes. We have to maintain a certain level of profitability. For us, to maintain the extra staff. For outside providers, to maintain a position in the network. They will not come around here if they are not making money.

. . . . . .

Interviewer: How many types of services do you offer on-site?

> **Manager**: We just started offering five. We were at four for the past two . . . maybe two and a half years. It was hard to get that fifth service in. With the revenues of the services, we were able to bring in another with very little financial impact.

Discussion

Creating a strong service network through on-site and community-based service activity brings together the advantages of both economies of scope and scale for managers and residents. By utilizing two models of supportive services, management can have access to a greater number of services as even turn a small profit. This, in turn, allows them to offer more services than the typical four included by most on-site service providers, as well as increasing the likelihood of supporting aging-in-place. Through economies of scale, residents can access reduced price services in a competitive market. Both scope and scale bring advantages to residents trying to access services.

While there are no "perfect" forms of this type of integration, the on-site and community-based service activity offers the greatest likelihood of long-term occupancy of apartment units by frail elders. Not surprisingly, this option is most closely associated with Section 202 housing types, specifically those facilities that have large homogeneous populations of elders. By concentrating elders in this residential environment, outside supportive service providers are better able to address the needs of this population in an efficient manner.

Summary

One of the most significant influences on the ability of a rent-subsidized housing project to maintain residents in their homes is its capacity to create networks or viable on-site alternatives to community-based services. These services--both on-site and

community-based--are the lifeblood to maintaining frail elders in their homes. If those services are not effective in addressing the core needs of the residents, or are too expensive, residents will be forced to move--either by the will of the manager, or the necessity to find a more supportive environment. The construction and maintenance of supportive service networks and on-site services are intimately linked with the facility type. Residents in very unsupportive facilities--those projects typically with smaller populations and lower concentrations of elders--tend to have access to very limited state-subsidized networks, or--more likely--secure services from non-contractual arrangements. This is not only an expensive proposition, but one that makes elders feel vulnerable to business that may not "have their best interests at heart." Additionally, residents bringing services into a housing project tend to view themselves as less healthy and less capable of making prudent long-term health care decisions. On the other hand, residents in supportive and highly supportive environments have on-site, or community-based services, or both to provide assistance with day-to-day activities. These residents have a greater chance to remain independent, consider themselves more healthy and capable in making long-term care decisions, than their less supported, heterogeneous project dwelling counterparts, and are less likely to be viewed as frail by managers.

CHAPTER 7
CONCLUDING REMARKS AND THE ROAD AHEAD

The Trees

The trees are coming into leaf
Like something almost being said;
The recent buds relax and spread,
Their greenness is a kind of grief.

Is it that they are born again
And we grow old? No, they die too.
Their yearly trick of looking new
Is written down in rings of grain.

Yet still the unresting castles thresh
In full grown thickness every May.
Last year is dead, they seem to say,
Begin afresh, afresh, afresh.

Philip Larkin
High Windows

Overview of Research

Florida contains one of the largest concentrations of low-income older persons (age 62 and over) found in government-subsidized rental housing--primarily administered by the Department of Housing and Urban Development (HUD). These elders are typically women who are over the age of 75, very poor and living alone. Because of their age and low income, they have few resources to meet their supportive service needs to age-in-place.

In terms of compatibility between services and needs in Florida, the state creates a burdensome eligibility and service structure to obtain long-term care assistance.

Additionally, these systems of support do not exist in sufficient quantities to meet either present or future needs of Florida's elder citizenry. With very few affordable housing options at any income level, low-income elders must confront a variety of obstacles in government-subsidized housing--reduced quality of life, extreme cost expenditures for needed services, loss of autonomy and control in premature institutionalization.

A strong rationale exists for understanding how issues of frailty, poverty, and supportive service needs come together in low-income housing. By understanding how to better support and encourage aging-in-place, elders can remain in their own homes, avoiding moving in with a family member, a board and care facility, or being prematurely institutionalized in a nursing home. State governments--responsible for funding Medicaid nursing home beds--can reduce their long-term care costs, while encouraging improved quality of life and community development of supportive services to meet the demands of local elder residents, by developing and encouraging community-based aging-in-place programs.

Goals

The purpose of this study was to gain a better understanding of the meanings both managers and frail elder tenants attribute to frailty and aging-in-place and explore how these meanings are influenced by the government-subsidized building context. These insights offer a view of management's attitude and philosophy of aging-in-place and the residents' views of the housing manager's policies.

The four major research questions addressed in this study are:

- To understand how managers and residents define frailty.
- To understand how managers and residents define aging-in-place.
- To understand how project size and density influence issues of frailty and aging-in-place.
- To identify major service delivery models in Florida's government-subsidized housing and how they are linked to economies of scope and scale.

Poor Elders

The condition of poverty is complex and should not be conceived of as a single problem with a single solution. Instead, race, gender, familial status, age, and place of residence all come together to influence the risk of living in poverty. In the elderly, these risks become even more influential in predicting poverty, the length of time an elder will spend in poverty, and the long-term occupancy of subsidized apartment units.

Currently, 10 percent of the nation's elderly--roughly 3 million people--have annual incomes below the official government defined poverty line. This group likely had low incomes throughout most of their adult lives, contributing to a lifetime of debilitating consequences that culminates in few resources, poor housing, significant health problems and dependence in old age.

HUD Facilities

By 1997, 1.6 million elders lived in federally subsidized housing. In Florida the older rent-subsidized population is top heaving with persons over the age 75, women, living alone, and African Americans. Low-income elders in the state have sought these housing alternatives that not only minimize monthly expenses, but also that maximize avenues for accessible supportive services and locales to remain at home. This population is concentrated in Section 202 housing projects (14,504 elders), followed by

Section 8 vouchers and certificates (12,754 elders), Section 236 (9,240 elders) with 4,398 elders utilizing other programs. Another 40,000 elders reside in facility types not investigated in this study. In all, about 80,000 elders live in Florida's government subsidized housing projects.

While many of the elders living in these housing facilities lead independent and active lives, a portion of them need some form of assistance with daily activities, including bathing, dressing, toileting, housekeeping, and shopping. If this group cannot maintain independent living arrangements, they become prime candidates for long-term care options--like nursing homes--potentially at the expense of state tax dollars.

Qualitative Investigation

To address the role of how the facility size and density influence the issues of frailty and aging-in-place, a qualitative methodological approach was undertaken. This method allows the strongest possibility of uncovering individual meaning ascribed to frailty and aging-in-place by both managers and elder tenants in the rent-subsidized housing environment. The use of this methodology is important in gaining a unique perspective of the life situation of the participants surrounding and structuring aging-in-place and frailty in the context of Florida's HUD housing facilities.

To measure this qualitative data interpretation, the computer program NUD·IST was utilized to search and structure the "talk database." The program provided a greater flexibility for searching the data for common meanings, ideas, and categories, as well as assisting with coding, of the interview transcripts.

Definitions

The three broad definitions under consideration in this research revealed dynamic constituent components. Within the areas of frailty, aging-in-place, and service delivery types, much variety was discovered within the framework of each definition.

Frailty

To attempt to classify residents of government-subsidized housing as frail without examining the relationship between the environment and the individual overlooks the dynamic set of environmental, physical, psychological, and social assets and deficits that comprise independence. Simply labeling residents as frail, negates any affects of supportive services that can be brought into the apartment to supplement activities of daily living (ADLs) or instrumental activities of daily living (IADLs), the type of housing environment the residents resides in, and the opportunities present in specific environments.

Of these four models, the most traditional--and most common--has been the **medical model**. This model uses the medicalization of the conditions of old age and their associated health symptoms to identify frailty. Though this model is, perhaps, one of the most amenable to treatment and supportive service, many studies have demonstrated that medical deficiencies do not equate with functional abilities. Many people labeled frail by this model can compensate with services and other forms of assistance.

The second model--the **service model**--examines conceptualizations of frailty based on access to services. Residents view frailty as a lack of access to services. As long as they have access to supportive services, there is no consideration of frailty. This

is most likely to occur in two categories of facilities--those that are highly supportive, where residents have become accustomed to available services and those that have few, if any, services available. In these two cases, residents see the services as "extensions" of themselves and their abilities. While this model is slow to develop, once accepted, it becomes firmly entrenched in the resident's mind.

The **individual model**, the third in this series, defines frailty on the basis of life expectations and experiences. Most often this occurs in residents that have strong memories of caring for aging parents or beliefs about what growing old is, or should be like. These people often have difficulties reconciling expectations versus the realities of aging, creating a need for services that is strongly individual-based and thus not always recognized by housing management. In this model, housing type continues to play a potentially major role in supporting the elder, particularly if services are an appropriate form of support.

The final model--the **manager model**--examines how managers conceptualize frailty by placing expectations and creating environments that to varying degrees meet the needs of residents. Managers often have the task of attempting to "hold the complex together" by making decisions to maintain or move residents. This process--as many have called it--is difficult because many of them work to keep their residents "at home." Unfortunately, many managers say they are willing to move one resident to maintain a coherent residential environment. This model of frailty becomes the "last stop" for many residents that have moved through the other models without enough support, assistance, or oversight, waiting for the "last straw" to move them into a nursing home.

Aging-in-place

To attempt to understand aging-in-place without examining the relationship between the environment and the individual overlooks the dynamic set of relationships that exist in government-subsidized housing. The factors influencing the long-term occupancy of any apartment unit are the result of the inter-locking relationship between housing type, the manager's approach to aging-in-place, and the supportive service needs of the residents.

This research defined three aging-in-place perspectives. They differ by the extent to which management is involved securing services for the housing project. Of the three models, the **inactive approach** to aging-in-place is, unfortunately, common and frequently encountered in Florida's heterogeneous housing environments, particularly Section 8s where elders make up a very low percentage of the overall population. By not providing supportive services, managers do not have to worry about frail elders, issues of aging-in-place, or long-term occupancy. This emphasis allows concentration on "bricks and mortar"--that is, traditional building management issues instead of supportive service provision and the constant need for assessment of the residential population.

The second model--the **reactive approach**--is the next most common example of aging-in-place program types in Florida's rent-subsidized housing. Managers provide services in reaction to residents' needs and moments of crisis. Often these service options are limited in scope, especially when compared to the service complement of Section 202 housing projects. To be fair, however, this approach is currently supporting a significant portion of residents in the state's subsidized housing program. The most significant fault of this model is that it provides no mechanism to ensure interaction

between residents and management. By having a service coordinator, long-term occupancy can be better guaranteed through constant interaction and assessment.

The final model--the **proactive approach**--offers the greatest hope for long-term care of seniors that are able to maintain independence or supportive service dependence without needing the medical advantages of a nursing home. By providing for ongoing and preventative assessments and interaction between residents and management, supportive services can be delivered in a proactive manner--addressing needs before they become a problem or crisis situation. This model has several other advantages, particularly because of the homogeneous residential environment in which this approach tends to manifest itself. By encouraging long-term occupancy in this type of environment, residents do not have the "friction" in the areas of morale, housing satisfaction, residential participation, and neighborhood motility. In "mixed population" housing types, many older residents have conflict or resentment with younger tenants over a variety of situations, including noise, children, crime, and issues of service access and utilization. A second important aspect of this type of project is the ability to consolidate services to take advantage of economies of scale in the provision and cost of supportive services.

Attempting to understand aging-in-place from the conceptualizations of managers and residents bring to the forefront the importance of environmental congruence. Thus, what occurs in the three models of aging-in-place is an intersection of personal and environmental factors, from both managers and residents, that contribute to the ability to inhabit an apartment unit for the long term. By addressing issues of aging-in-place in this manner, individual residents can discern their ability to remain at home, while

maintaining control over their own health, and have the opportunity to change their life situation through policy and programmatic interventions.

Service Delivery Types

Attempting to understand issues of frailty and aging-in-place through supportive service acquisition and facility type sheds light on the important role of the service networks and how they are incorporated into the housing project. Understanding how these networks, or lack of a network, contributes to low-cost services for residents, additional revenue streams for projects, and the ability of a project to secure community-based resources, identifies the role that housing facility will play within a community or region, the types of elders it will be able to serve, and the interest of the manager and housing project to maintain frail elders in their homes.

The four models of service integration discussed in this chapter illustrate how economies of scope and scale manifest themselves in Florida's government-subsidized housing, and maintain, or limit, frail elders aging-in-place. The **service inactivity** model provides for no services to be offered on-site. Additionally, no service contracts are arranged with community providers. Residents may opt to select services from the community, but few--likely--make that choice due to expense, lack of knowledge, or unrealistic view of their own health and well being. To further complicate matters, this form of integration is encountered in projects with small populations/low concentrations of elders. Managers, likely, do not have extensive experience with elder issues; and, therefore, do not have a strong tolerance for deficits in activities of daily living.

The second economic model--**community-based activity**--is, usually, the first step low population/low density housing projects take in securing services for frail, elder

tenants without committing the project to on-site services. The supportive services offered by housing facilities do not originate on-site, rather they are brought in from community-based providers. Though residents may opt for a service provider not under contract, many do not simply due to cost. By making services available in this manner, frail residents have some guidance in determining services appropriate to their needs and financial standing, as well as a recognized and knowledgeable source for getting needed services.

The third economic model--**on-site service activity**--focuses managers' interests on economies of scope to maximize the number of services offered through on-site employees, taking full advantage of knowledge, resources, and skills available at this single location. This model is typically a "building block" model for projects that hope to expand into the third integration model by adapting community services to fit the needs of tenants. Typically, this type of integration is found in small population/low density projects, but is also exhibited in steadily growing, predominantly elder-occupied facilities.

On-site and community-based service activity--the fourth economic model--demonstrates the strengths of combining on-site services with the advantages of model two. By having both on-site and community-based services, residents have distinct advantages that are not available in facilities offering either integrative model one or two. Residents have large selections and low prices for needed services. Though typically available in large, predominantly elder-occupied facilities, facilities containing smaller concentrations of residents are attempting to replicate the success of these projects. By

providing both types of services, these facilities have a significant better opportunity of addressing and maintaining frail, elder residents to age-in-place.

These integrative models further demonstrate the significance of building type and supportive service commitment to keeping frail elders in their homes, understanding environmental congruence, and identifying factors contributing to frailty. Through the creation and maintenance of supportive service networks--on-site and in the community--government-subsidized housing managers can better maintain oversight of their residents while addressing their day-to-day service needs.

Major Results

Within the context of the HUD residential facility's environment, managers and residents construct meanings of frailty and aging-in-place through their day-to-day actions and interactions. The results of this investigation revealed that both groups approach these definitions from personal perspectives that influence environmental congruence and the construction of frailty and aging-in-place as important components of aging-in-place.

Frailty

The conceptualization of frailty in government-subsidized housing encompasses a broad spectrum of possibilities. Most residents were highly tuned to their residential environments, the support or lack thereof by facility staff, and ability to access on-site and nearby services, like housekeeping assistance, transportation, medical facilities, or meals. Residents in very unsupportive facilities--like those of Section 8 facilities--not only did not feel they were capable of taking care of themselves as well as other seniors in this research, but did not exhibit high satisfaction with their residential environment,

fellow neighbors, or quality of life. On the other hand, residents with supportive services at the HUD facility, possessed high satisfaction with their life, facility staff, and activity levels. Frailty for most residents--though often thrust upon them as a label or diagnosis--did not influence residents in their self-reporting of frailty. Residents neither viewed themselves as frail, nor believed they were frail simply because managers or doctors declared them so. In facilities that offered supportive services, particularly high levels of services combined with design modifications like those of Section 202 housing, managers and residents were less likely to consider themselves frail or have managers consider them frail.

Aging-in-Place

Low-income, government-subsidized housing offers varying supports for aging-in-place. Most managers were supportive of their residents to age-in-place, even if that support was limited to words of encouragement or the tenuous provision of services. They worked within the guidelines of their facilities and the supportive services that were immediately available. Those managers who did not support this principle, most often managed facilities that had few, or very few, elders with little likelihood of gaining community support for services. The three approaches to managerial aging-in-place were strongly associated with the type of facility, size of the population, and concentration of the elder tenants. Managers who applied the **inactive approach** to their facilities created environments that had no concern for their residents, their needs, or their long-term occupancy of apartment units. These highly unsupportive facilities had very few long-term residents in their eighties and nineties. On the other hand, managers who engaged the **reactive** and **proactive approaches** to aging-in-place had much better success at

retaining and maintaining long-term elder populations. While the **reactive approach** only demonstrated limited success, the **proactive approach** offered highly supportive environments with many frail, though independent residents.

Managers and residents approach this issue of aging-in-place from opposite ends of the spectrum. For long-term occupancy of government-subsidized housing, both managers and residents need to work toward a common goal, instead of seeking to solve Managers seek to limit "triggering" behaviors and mechanisms in residents that demonstrate their inability to cope with the residential environment; in effect hoping they will not exhibit "signs" of needing to be moved to a new residential environment. Residents, on the other hand, view services as the best means at judging whether they can remain in their apartments. The success of aging-in-place programs is tied to the ability of the environment to limit frailty by providing services to support elders in their day-to-day activities.

Economies of Scope and Scale

One of the most significant influences on the ability of a rent-subsidized housing project to maintain residents in their homes is its capacity to create networks or viable on-site alternatives to community-based services. These services--both on-site and community-based--are the lifeblood to maintaining frail elders in their homes. If those services are not effective in addressing the core needs of the residents, or are too expensive, residents will be forced to move--either by the will of the manager, or the necessity to find a more supportive environment and services. The construction and maintenance of supportive service networks and on-site services are intimately linked with the facility type. Residents in very unsupportive facilities--those projects typically

with smaller populations and lower concentrations of elders--tend to have access to very limited state-subsidized networks, or--more likely--secure services from non-contractual arrangements. This is not only an expensive proposition, but one that makes elders feel vulnerable to business that may not "have their best interests at heart." Additionally, residents bringing services into a housing project tend to view themselves as less healthy and less capable of making prudent long-term health care decisions. On the other hand, residents in supportive and highly supportive environments have on-site, or community-based services, or both to provide assistance with day-to-day activities. These residents have a greater chance to remain independent, consider themselves more healthy and capable in making long-term care decisions, than their less supported, heterogeneous project dwelling counterparts, and are less likely to be viewed as frail by managers.

Significance

The results of this project produced the following four programmatic impacts:

- A more complete understanding and definition of frailty from managers and residents of Florida's low-income, government-subsidized housing projects
- A more complete understanding and definition of aging-in-place from managers and residents of Florida's low-income, government-subsidized housing projects
- A better understanding of the relationship between project size and density and how these factors influence issues of frailty and aging-in-place
- A better understanding of the role of economies of scope and scale in supportive service models of Florida's low-income, government-subsidized housing projects.

Programmatic Impact One

Managers and residents appraised their issues of frailty similarly. Residents define their frailty in relation to the environment in which they live. Most elder tenants are highly tuned to their residential environments, the support or lack thereof by facility staff, and the ability to access on-site and nearby services as dictated by facility type.

Managers' views of frailty originated in the interaction between resident and housing environment. Managers in housing types with few supportive services judged elders much more stringently. Those environments with supports tended to elicit more relaxed views of frailty and the role of supportive services in that judgment.

The four models of frailty uncovered by this research indicate a strong relationship between the environment of the housing facility and each resident's physical characteristics that together produce different manifestation of frailty within the housing environment.

Understanding these issues not only encourages residents to take control of their own health and well being, but also points to the need for housing environments that create residential settings that addresses tenant shortcoming by facility managers to prepare for the inevitable progression of supportive service need as a population ages-in-place.

Programmatic Impact Two

Managers and frail elders—generally--appraised their abilities to age-in-place very closely. Interestingly, managers and residents have the greatest concurrence in facilities like Section 202s, Section 221s, and Section 236s where the two groups interact frequently--or work with a service coordinator--to maintain independence through supportive services.

The key for the two groups of actors to assessing issues of frailty and aging-in-place is to have frequent contact with management and staff. Without management taking an interest in their frail, elder tenants and without tenants expecting some form of

guidance from management, neither group will have success in the long-term occupancy of these apartment units.

Programmatic Impact Three

Most managers are not willing to commit to aging-in-place support without having an appropriate facility type and supportive services in-place. Facilities with smaller populations and lower concentrations of elders have little interest in maintaining frail elder tenants in their homes for the long-term. Most facilities with sufficient population numbers, however, have physical plants to support aging-in-place--even if on modest terms. Most of Florida's low-income, government-subsidized housing projects have some interest in maintaining this population as demonstrated by their concerns over senior supportive services at community levels and on-site. Similarly, most managers realize that supportive services offer the most cost-effective means of maintaining low costs and ensuring high quality of life for this sub-group of Florida's senior population.

Programmatic Impact Four

Economies of scope and scale contribute to the opportunities a residential site can offer to frail, elder tenants. Without low-cost, supportive services and/or a variety of needed services, elders would be forced from their apartments in many of the housing projects involved in this study. The construction and maintenance of supportive service networks--either on-site or at community-based locations--translate into elders being able to age-in-place.

The four economic models revealed in this research demonstrate the importance of integrating economies of scope and scale into government-subsidized housing. They allow for projects to provide a variety of services very efficiently at relatively low cost.

Including issues of economies of scope and scale in the understanding of aging-in-place and frailty is crucial to understanding the complete picture of the problem facing frail elders in subsidized housing. Supportive service networks--built on the principles of economies of scope and/or scale--are the very substance of keeping frail elders in their apartments for the long term. Without continued development, few service networks will be able to maintain the current numbers of elders in Florida subsidized housing projects or be able to support the expected age wave of elders in the near future.

Concluding Remarks

With an estimated 80,000 elder tenants in Florida's subsidized housing projects, it is critical to have an understanding of the issues of frailty and aging-in-place to adequately address the supportive service needs of this group. In many cases, just a little assistance--a personal health aid to assist with grooming or bathing--can mean the difference between staying in the apartment that has become home or having to move out. As the average age of seniors is increasing in Florida's HUD subsidized housing, so too has their demand for supportive services. Without access to some form of assistance, these frail elders have a much greater risk of entering a nursing home. This premature institutionalization not only lowers quality of life, but also--potentially--could significantly impact taxpayers.

For aging-in-place initiatives to really work, a wide variety of housing and service choices that address the needs of the local aging population are necessary. This concept works best as part of a comprehensive approach to support the needs of the frail low-income elders of Florida's government-subsidized housing. By bringing together the issues of frailty, economies of scope and scale, and facility types, the complex facets of

aging-in-place can be better understood and implemented. This type of program is the most dignified and cost-efficient means to provide long-term care to this low-income population.

This importance of these findings is not simply for researchers or gerontologists, but concerned members of Florida's community at-large. People must realize that these steps of bringing services into low-income housing projects have not only fiscal results, but improve the quality of life of senior residents and allow them to choose where to age-in-place with dignity and autonomy, giving them a home until *they* choose to move.

APPENDIX A
A BRIEF HISTORY OF THE UNITED STATES PUBLIC HOUSING PROGRAM

The public housing program in the United States dates back to the Housing Act of 1937. As with many other public programs, the evolution of this agenda was due primarily to Marie McGuire Thompson for transforming the modest program designed to address some of the housing needs of low-income families into what is now a major component in meeting the housing needs of low-income elders. In addition to Marie McGuire Thompson's efforts, there have been four pieces of critical legislation that have dramatically changed the direction of public housing – The Housing Act of 1956, The Housing Act of 1970, The Congregate Housing Services Program of 1978, and The National Affordable Housing Act of 1990.

The Housing Act of 1956

Although public housing as a federal program dates back to the 1930s, the Housing Acts amendments of 1956 are the first recognition of older adults as a distinct population in need of public housing assistance. Until these amendments were enacted, single elderly persons were not eligible for admission to public housing. A more important contribution of this amendment was that they authorized the Federal Public Housing Administration to assist in the construction of new housing or the remodeling of existing housing in order to provide accommodations designed specifically for elderly households.

The decade of the 1960s was a period of vast expansion for public housing for seniors. Prior to the Housing Act of 1956, roughly only 6 percent of the public housing residents were elderly. By 1957, the number had increased only slightly to about 11 percent. In the 1960s, the percentage of seniors in public housing had risen to the low thirties. Subsequent decades have continued to show a consistent and steady increase, reaching a peak in the late 1970s with approximately 46 percent. From this high, current percentages of elders in public housing have remained steady around 38 to 40 percent. Although part of this decline is due to a different age base (i.e. 65), it also reflects an increased occupancy of public housing by families. Such distinctions are critically important to this dissertation research and that of Golant (1999). Public housing – particularly Section 8 – creates a truly unique environment for seniors, raising a series of problems centering around service acquisition and provision.

This act had one other significant contribution. The opening of senior public housing facilities to occupancy by older adults stimulated public housing development in states where no previous activity had taken place. According to the U. S. Department of Housing and Urban Development, by 1978, six states, Iowa, Kansas, Minnesota, Nebraska, North Dakota, and Wisconsin, all reported occupancy rates of over 66 percent.

The Housing Act of 1970

While authorization for public housing agencies to construct or rehabilitate congregate housing facilities was not enacted until 1970, the seeds for the development of this housing type came in 1963. Backed by a statement of support by President Kennedy, a Memorandum of Understanding was signed by the Commissioner of Public Housing and the Commissioner of Welfare in the United States Department of Health, Education

and Welfare on October 24, 1963. This document called for a "pilot" congregate housing program specifically designed for older residents under which the Public Housing administration would provide assistance for the same categories of space, equipment, and furnishings for which assistance is made available in self-contained dwellings. Further these new facilities would include: (1) space for common eating arrangements, (2) kitchen equipment, (3) space, furniture, and furnishings for lounges including a snack kitchen. The Department of Health, Education, and Welfare agreed that these facilities would be staffed and operated with local or state welfare funds that were reimbursable by the federal government. At the time the memorandum was signed, one public congregate housing facility was under construction and the applications for four others were pending.

Local public housing agencies were cautious in developing congregate housing following the 1963 pilot program. There were two main reasons for this. First, a commitment was required in the form of a financial guarantee, made by a public source, insuring the continued operation of the dining facility. Second, many public agencies were reluctant to take on the additional responsibilities of support services for frail elderly persons when they did not have a secure source of funding and no staff who were trained to coordinate services. Despite these deterrent, a few local agencies proceeded with plans to develop specially designed congregate public housing for older adults.

The early history of congregate housing for the elderly can best be described as slow. However the concept continued to receive public attention and support. This attention culminated in the provisions of the Housing and Urban Development act of 1970 which authorized the use of up to 10 percent of all public housing development

contract authority for the development of congregate housing for the elderly, the displaced, or the handicapped.

The Congregate Housing Services Program of 1978

Even as late as 1978 there remained serious constraints to program expansion, particularly in the area of providing support services. As a result, significant new incentives were made available under the congregate housing services section (Section 401) of the Housing and Community Development Amendments of 1978. This legislation authorized a comprehensive approach to funding the support services of congregate facilities located in public housing and in HUD Section 202 housing. This legislation resulted in a demonstration program involving thirty-three public housing agencies and thirty HUD Section 202 non-profit housing sponsors.

The National Affordable Housing Act of 1990

Section 802 of the National Affordable Housing Act of 1990 restructured the congregate Housing Services Program and expanded its coverage. Federal funding was made available for public housing and for housing provided under HUD Section 202, HUD Section 8, HUD Section 221-d-4, and HUD Section 229. Further, the new law included assisted housing provided under Section 514 and 515 of the Farmers Home Administration (FmHA). Unlike the previous congregate housing services program, which provided for a 75 percent federal contribution, the 1990 law divides the costs among the federal government (40 percent), the local housing authority (50 percent), and the residents (10 percent). Under the provisions of the new law, funds may be used for retrofitting individual units and common spaces. Further, meals are a required

congregate service that must meet at least one-third of the daily nutritional requirements of the residents. Funds may also be used to pay for a service coordinator.

Although the 1990 law authorized $25 million in Fiscal Year (FY) 1991 and $26 million in FY 1992, the Appropriations Committees of Congress made available only $18 million for FY 1991. This amount is sufficient to fund the sixty existing CHSP projects and an estimated sixty additional facilities. These additional programs would increase the number of older people served to only 4,000 elders.

Housing Programs of the Department of Housing and Urban Development

The federal government through the Department of Housing and Urban Development (HUD) operates a diverse array of rent-subsidized housing and supportive service programs for elders. A brief summary of the programs applicable to this study are discussed below.

Section 8 Rental Certificates

This program was authorized as low-income rental assistance under Section 8 of the U. S. Housing Act of 1974. Section 8 rental certificates currently pay the difference between 30 percent of an individual's adjusted income and the established fair market rent for the house or apartment being rented. HUD Section 8 is administered by a local housing authority, and individuals and families receiving the certificates may locate housing anywhere within the housing authority's jurisdiction. Further, recipients are free to negotiate a lease with the owner. The unit chosen must meet HUD's quality standards and the owner must be willing to accept the Section 8 certificate for the designated portion of the rent. Historically, Section 8 housing has been available in two forms:

1. Section 8 certificates are available as rental assistance to eligible individuals and families. There are approximately 1.2 million certificates currently in circulation, of which about 37 percent are used by elderly persons.

2. Section 8 is also coupled with all Section 202 projects approved between 1976 and 1990. This subsidy is made directly to the project owner and not the individual. Approximately 200,000 people are currently housing in Section 202/8 projects (for a complete description, see the section below).

A new version of Section 8 involves the use of what are called "rental vouchers." This program was established as a demonstration project in 1983 and was converted into a permanent program in 1989. The voucher program is essentially the same as HUD Section 8 rental certificates except that the rent charged for a unit may exceed the fair market rent limit for a particular jurisdiction. In that even the voucher holder pays the additional cost. Another initial difference was that the voucher was "portable" in that it did not have to be utilized in the jurisdiction for which it was issued. Currently both HUD Section 8 certificates and voucher are portable.

HUD Section 202

Although the Section 8 Program is the largest of the HUD housing programs, the Section 202 program is probably the most visible and the best known. Section 202 was initially established by the Housing Act of 1959. Funds were first appropriated in October 1960 for a $20 million pilot program. Section 202 used low interest direct loans with a fifty-year payback period. Between 1959 and 1970 Section 202 was an "over-the-counter" program in which any interested sponsoring organization could go to a local HUD field office, present plans and get funding approval. The program was small but it produced excellent sate-of-the-art housing utilizing the latest design ideas. Approximately 300 projects with 45,000 units were built with an average size of 133 units. About 25 percent of the projects had a mandatory meal plan included as a

condition of occupancy (U. S. Senate 1984). The program was suspended by the Nixon administration in 1970 and replaced with HUD Section 236. About 150 projects that had already been approved as well as a few completed projects were then converted to the Section 236 program.

HUD Section 202/B

With the passage of the Housing and Community Development Act (HCD) of 1974, Congress combined Section 202 with Section 8 and authorized a new program designated as Section 202/8. This revised program was implemented in 1976 with 30,000 units in 289 projects funded that year. Under the revised plan, the Section 202 program was converted to a national competition, with projects approved at the national level. The sponsoring organizations had to set up a single-purpose "borrower" corporation which received the funding award and thus owned and operated the project. Until 1990, borrowers could receive a direct loan from the federal government, at slightly below market rates, to finance construction. The loan was then repaid through a forty-year mortgage. Projects for the elderly approved through 1990 are coupled with 100 percent Section 8 rental assistance. The average size of projects approved between 1976 and 1980 was sixty-five units. HUD – under a directive from Congress – prohibited the implementation of mandatory meals programs in any project completed after April 1, 1987.

During the period 1981-1989, HUD imposed a severe "cost containment" policy on projects approved under Section 202/8. This policy was implemented to cut the cost of building the projects by utilizing cheaper materials and eliminating two-bedroom units, downsizing one-bedroom and efficiency units, cutting down or eliminating common

space, meeting rooms and congregate facilities, eliminating elevators in two-story buildings, and prohibiting balconies or covered entrance ways.

Due to these restrictions, meals programs disappeared as many projects no longer had the necessary community or office space. Increasingly tighter regulations were imposed and with Fair Market Rents artificially suppressed by HUD policies (U. S. Senate 1989) it became all but impossible to build projects in many parts of the country without substantial sponsor contributions or supplemental financing from other sources. Tighter regulations at the field office level also increased the time it took to get a project through the approval stage. Additionally, it became common for the process to take three years from initial selection to occupancy. These restrictions were loosened somewhat in 1989 and were subsequently all but removed by the passage of the National Affordable Housing Act (NAHA) of 1990.

Additional changes to this program were by Section 801 of the national Affordable Housing Act of 1990. Among these changes are:

1. Direct loans were abolished and replaced with a capital advance which does not have to be repaid if the project is utilized for its original purpose for at least forty years. This capital assistance effort operates essentially as a grant;

2. The cost of a project is based upon local cost standards rather than Fair Market Rents. Incentives are provided so that owners who build projects for less than the initial estimates may retain 50 percent of the savings for certain designated uses, and may retain 75 percent of the savings if they add certain energy efficient features;

3. Nonelderly disabled are no longer allowed to live in projects for the elderly financed under Section 202. New projects built under Section 202 from FY 1991 onward will only accept elderly persons for tenancy;

4. Project managers may now include staff who will coordinate supportive services in their budgets. Additionally, project rental assistance funds may be used to pay for a portion of certain necessary supportive services.

HUD Section 221(d)

HUD Section 221(d) consists of two types of mortgage insurance for privately-financed loans to build multi-family projects (which could include projects for the elderly). Initially authorized in the 1950s, Section 221(d) is an over-the-counter effort similar to the original Section 202 program, in which owners present plans and proposals to the HUD field office for approval. These projects may be owned by either a nonprofit or a limited dividend owner. Income limits are not applicable for this program but many of the projects do utilize Section 8 certificates. The major difference is that 100 percent of the mortgage may be insured by the government for non-profit and cooperative mortgagors under Section 221(d)(3), but the government insures only 90 percent of the mortgage under 221(d)(4) irrespective of the type of mortgagor.

While this program has never been officially suspended, activity has been minimal since the mid-1980s. One major difference of note is that these projects are not specifically limited to the elderly and in many cases have large numbers of nonelderly disabled people living in them.

HUD Section 221(d)(3) Retirement Service Centers

This program, which was in operation from 1983 to 1989, consisted of federal mortgage insurance on privately financed projects. The program was specifically designed to develop congregate facilities for low- to moderate-income frail elderly who were expected to pay market rates for both rent and supportive services. Under this program 186 projects providing approximately 26,5000 units were insured.

One main problem of these types of facilities was that there were too few elderly in the narrowly defined income range targeted by the program to make it possible to

support the numbers of projects being insured. This was especially true in a number of locations where these projects were concentrated – Cincinnati, Ohio; Phoenix, Arizona; and Minneapolis-St. Paul, Minnesota. The reasons for the failure of this program are few, but severe – poor loan writing, overly optimistic financial and marketing projections and, most importantly, inadequate reserves.

HUD Section 236

HUD Section 236 was designed for rental and cooperative housing in which there was federal mortgage insurance on a private market-rate loan. It also provided interest reduction payments to reduce the effective interest rate to one percent. Section 236 was initially authorized under the Housing and urban Development Act of 1968. Tenant eligibility was established with rental limits, and rental rates were either the basic rental charge based upon a one percent interest rate, or 25 percent of income, whichever was less. Some residents paid the fair market value for the apartments while others received rent supplement payments. Some of these projects have mandatory meals programs. Section 236 projects, generally, operate under similar occupancy rules as do those projects for the elderly under the Section 202/8 program. The Section 236 program was suspended in 1976.

APPENDIX B
HOUSING TYPES

Section 202, Supportive Housing for the Elderly Program. Since 1959 this program has persisted as the primary financing vehicle for constructing subsidized rental housing facilities for low-income elderly. Sponsors are private nonprofit organizations, and occupancy is now open to very low-income (under 50 percent of the area's median income) elderly persons age 62 years or older. While now targeted to seniors, its occupants include nonelderly disabled tenants who before 1990 were eligible tenants. Annual housing construction of this program has declined from its earlier high, even as advocates and experts have recognized its record of sound management, long waiting lists, and its benefits enjoyed by its less independent elder tenants.

The funding mechanisms for this program have changed since its inception. Currently, its provides capital to finance the construction and rehabilitation of buildings that will serve as supportive housing for very low income elderly persons and it provides rental assistance payments to help make their units affordable. Many, but not all, of the buildings have several congregate areas (e.g. central dining room, community rooms, library). Along with expanding the supply of affordable housing, this program is designed to allow sponsors to provide supportive services for elderly participants, such as personal care, meals, health services, housekeeping, and transportation. These are largely funded, however, by non-HUD or public sources including the housing sponsor, area or state agencies on aging, county or state health departments (Title XIX-Medicaid), county or state welfare department (Title XIX-Community Services Block Grants of the Social Security Act), city, county, state or third party grants (e.g. foundations), and / or user fees.

Section 8 Noninsured Facilities. This program, originally established by the Housing and Community Development Act of 1974, is managed by HUD's Office of Housing (as opposed to Section 8 Certificates and Vouchers managed by the Office of Public and Indian Housing). HUD contracts directly with and provides rental subsidies to privately owned apartment housing. These subsidies (for up to 20 to 40 years, depending on financing) are tied to specific property units (project-based assistance) and are paid to private owners/sponsors (profit and non-profit) on behalf of their eligible tenants. Under the program, very low-income (at or below 50 percent of the median income) residents in subsidized units generally pay 30 percent of their income for rent and HUD pays the balance. This program was designed both to assist tenants with income too low to obtain decent rental housing in the private market and to encourage new construction and properties requiring substantial rehabilitation. The program was largely eliminated in 1983 due to high cost.

Section 221 (d) (3) and Section 221 (d) (4). The Federal Housing Administration (FHA) insures mortgages made by private lending institutions to help finance the construction or substantial rehabilitation of multi-family rental or cooperative housing project with five or more units. Projects may be designed wholly or partially for low- to moderate-income residents who are elderly (age 62 or older) or have disabilities. The principal difference between the (d) (3) and (d) (4) programs is the amount of insured mortgage available to nonprofit and profit motivated sponsors. These programs are available as alternatives to the Section 231 Program, now largely inactive (only one facility in Florida). Legislation establishing the Section 221 (d) (3) program was enacted in 1954; for the Section 221 (d) (4) program, 1959. While there are no income limits for these programs, Section 221 insured properties often are linked with Section 8 rental-assistance to make them more affordable to low-income tenants.

Section 236. Enacted in 1968, Section 236 provides monthly subsidies to private sponsors, reducing the interest rate to as low as one percent on 40-year insured mortgages for new multi-family rental projects wholly or partially occupied by elder tenants. Usually ten percent of the units are designated for persons with mobility impairments. Section 236 projects can include self-contained apartments, congregate facilities or a combination of the two. They can also contain dining hall, community rooms, and health care services. To insure that very low-income tenants (at or below 50 percent of area median income) do not pay more than 30 percent of their incomes on their rent, Section 236 projects have been eligible for rental assistance payments. No new subsidy commitments have been made under this program since 1973. The smaller rent revenues of Section 236 projects--even with Section 8 subsidies--severely restrict the operating budgets of these facilities and in turn the resources that can be allocated to staffing and services relevant to the needs of frail tenants.

REFERENCES

Altman, I. & Rogoff, B. (1987). World Views in Psychology: Trait, Interactional, Organismic, and Transactional Perspectives. In D. Stokols & I Altman (eds.), *Handbook of Environmental Psychology*: Volume 1. New York: Wiley, pp. 1-40.

American Association of Homes and Services for the Aging. (1997). *Affordable Assisted Living: Options for Converting or Expanding Housing to Assisted Living.* An AAHSA Technical Assistance Brief. Washington D.C.

American Association of Retired Persons. (1999). *A Profile of Older Americans: 1998.* Washington, D.C.: AARP Resource Services Group.

American Association of Retired Persons. (1998). *Staying at Home: A Guide to Long-Term Care and Housing.* Washington, DC: AARP Resource Services Group.

American Association of Retired Persons. (1991). Senior Housing Developments Assume New Role as Community Service Centers, Part 2. *AARP Housing Report.* Washington, D.C.: AARP Consumer Affairs and Program Department, Winter.

American Association of Retired Persons. (1990). Senior Housing Developments Assume New Role as Community Service Centers, Part 2. *AARP Housing Report.* Washington, D.C.: AARP Consumer Affairs and Program Department, Fall.

Apgar, Jr., W., DiPasquale, D., McArdle, N., & Olson, J. (1989). *The State of the Nation's Housing, 1989.* Cambridge, MA: Harvard University Press.

Arluke, A. & Peterson, J. (1981). Accidental Medicalization of Old Age and Its Social Control Implications. In C. Fry (ed.) *Dimensions: Agingin, culture and Health.* New York: Praeger, 217-284.

Avant, W. & Dressel, P. (1980). Perceiving Needs by Staff and Elderly Clients: The Impact of Training and Client Contact. *The Gerontologist*, 20, 71-77.

Barker, R. (1968). *Ecological Psychology.* Stnaford, CA: Stanford University Press.

Barker, J. Mitteness, L. & Wood, S. (1988). Gate-Keeping: Residential Managers and Elderly Tenants. *The Gerontologist*, 28, 610-619.

Bartlestone, R. (2000). Housing and Services for Frail Seniors Interview. June 10.

Bechtel, R. (1997). *Environment & Behavior: An Introduction.* Thousand Oaks, CA: Sage Publications.

Becker, G. (1994). The Oldest Old: Autonomy in the Face of Frailty. *Journal of Aging Studies*, 8, 59-76.

Bennett, V., Starr, N., & Zierman, C. (nd). *Linking Housing and Services: A Flexible Delivery System Strategy.* St. Paul, MN: Wilder Research Center.

Bernstein, J. (1982). Who Leaves -- Who Stays: Residency Policy in Housing for the Elderly. *The Gerontologist*, 22, 305-313.

Birren, J., Lubben, J., Rowe, J. & Deutchman, D., eds. (1991). *The Concept and Measurement of Quality of Life in the Frail Elderly.* New York, NY: Academic Press, Inc.

Black, B., Rabbis, P., German, P., McGuire, M. & Roca, R. (1997). Need and Unmet Need for Mental Health Care Among Elderly Public Housing Residents. *The Gerontological Society of America*, 37, 717-728.

Blandford, A., Chappell, N. & Marshall, S. (1989). Tenant Resource Coordinators: an Experiment in Supportive Housing. *The Gerontological Social of America*, 29, 826-829.

Bourne, L. (1981). *The Geography of Housing.* London: Edward Arnold Publishers.

Brice, G. & Corey, K. (1991). Facilitating Federally Subsidized Housing Managerial Role Expansion: Beyond "Bricks and Mortar" to Lifespace Intervention with Vulnerable Older Tenants. *Journal of Applied Gerontology*, 10, 486-498.

Brown, I., Renwick, R., and Raphael, D. (1998). Frailty: Constructing Common Meaning, Definition, and Conceptual Framework. *Canadian Journal of Public Health*, 86, 371-385.

Callahan, J., Jr., ed. (1993). *Aging in Place.* Part of the Generations and Aging Series. Amityville, NY: Baywood Publishing Company, Inc.

Callahan, J. & Lanspery, S. (1997). Can We Tap the Power of NORCS? *Perspectives on Aging*, 26, 13-20.

Callahan, J. & Lanspery, S. (1991). *Supportive Services in Senior Housing: Lessons from the Robert Wood Johnson Foundation.* Paper presented at Supportive Services Program in Senior Housing, Waltham, MA.

Campbell, J. (1997). Unstable Disability and the Fluctuations of Frailty. *Age and Ageing*, 26, 315-319.

Campbell, P. (1994). *Population Projections for States, by Age, Race, and Sex 1993 to 2020*. Washington, DC: U.S. Bureau of the Census, Current Population Reports, P25-1111, U.S. Government Printing Office.

Chandler, Jr., A. (1990). *Scale and Scope: The Dynamics of Industrial Capitalism*. Cambridge, MA: Belknap Press of Harvard University Press.

Chapman, N. (1991). The Role of Family and Friends in Quality of Life. In J. Birren, J. Lubben, J. Rowe & D. Deutchman (eds.), *The Concept and Measurement of Quality of Life in the Frail Elderly*. New York: Academic, 172-190.

Clapham, D., & Smith, S. (1990). Housing Policy and "Special Needs." *Policy and Politics*, 18 (3), 193-205.

Clark, R. & Quinn, J. (1999). *The Economic Status of the Elderly*. Internet: WWW.nasi.org/Medicare/Briefs/medbr4.htm. Accessed: August 4, 2000, no pagination.

Cluff, L. (1996). The Role of Technology in Long-Term Care. In R. Binstock, L. Cluff, & O. Von Mering (eds.), *The Future of Long-Term Care: Social and Policy Issues*. Baltimore, MD: The Johns Hopkins University Press, 97-118.

Conrad, P. & Schneider, J. (1980). *Deviance and Medicalization: From Badness to Sickness*. St. Louis: Mosby.

Couglin, K. (1998). *Fair Housing: Non-Elderly Persons in Elderly Housing*. An AAHSA Technical Assistance Brief. Washington, D.C.

Coward, R. (1997). *Poverty A Major cause of Declining Health Among the Elderly*. Internet: WWW.Docguide.Com/dg/8f10f557991. Accessed: August 4, 2000, no pagination.

Cowing, T., & Holtmann, A. (1983). Multiproduct Short-Run Hospital Cost Functions: Empirical Evidence and Policy Implications from Cross-Section Data. *Southern Economic Journal*, 49, 637-653.

Cresswell, J. (1994). *Research Design: Qualitative & Quantitative Approaches*. Thousand Oaks, CA: Sage Publications.

Daskal, J. (1998). *In Search of Shelter: The Growing Shortage of Affordable Rental Housing*. Center on Budget and Policy Priorities. Washington, D.C.: Center on Budget and Policy Priorities.

Davis, H., Lindsey, W., Neuman, S., & Turner, P. (1998). Bricks and Mortar or Helping Hands? An H/CD Debate. *Journal of Housing and Community Development*, 55, 15-24.

Denzin, N. & Lincoln, Y. (1994). *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage Publications.

Diwan, S. & Moriarty, D. (1995). A Conceptual Framework for Identifying Unmet Health Care Needs of Community Dwelling Elderly. *The Journal of Applied Gerontology*, 14, 47-63.

Dreyer, S. (1992). *National Institute of Senior Housing: Six Agencies Link Housing and Services*. Washington, D.C.: NCOA Networks.

Dunlop, B., Lazarus, W., Polivka, L., Rothman, M., & Williams, J. (1996). *Long Term Care in Florida: Needs, Costs, Forecasts and Program Infrastructure* (Volume 1). The Commission on Long Term Care in Florida. Tallahassee, FL: The Commission for Long Term Care in Florida.

Dychtwald, K. & Flower, J. (1989). *Age Wave: the Challenges and Opportunities of an Aging America*. Los Angeles, CA: Jeremy P. Tarcher, Inc.

Everding, G. (1999). *Study Shows Poverty Common Among Aging*. WWW.wupa.wustl.edu/record/archive/1999/09-16-99/articles/poverty.html. Accessed: August 4, 2000, no pagination.

Feder, J., Scanlon, W., & Howard, J. (1992). Supportive Services in Senior Housing: Preliminary Evidence on Feasibility Impact. *Generations*, 16 (2), 61-62.

Federal Interagency Forum on Aging Related Statistics. (2000). *Older Americans 2000: Key Indicators of Well-Being*. Washington, D.C.: Office of Management and Budget.

Feldman, P., Latimer, E., & Davidson, H. (1996). Medicaid-Funded Home Care for the Frail Elderly and Disabled: Evaluating the Cost Savings and Outcomes of a Service Delivery Program. *HSR: Health Services Research*, 31, 489-508.

Fineman, N. (1994). Health Care Provider's Subjective Understandings of Old Age: Implications for Threatened Status in Late Life. *Journal of Aging Studies*, 8, 255-270.

Fischer, L. & Frank, M. (1994). Aging-in-Place: The On-site Coordination Study in Minnesota. Presented at the American society on Aging. San Francisco, CA.

Fonda, S. Maddox, G., Clipp, E., & Reardon, J. (1996). Design for a Longitudinal Study of the Impact of an Enhanced Environment on the Functioning of Frail Adults. *The Journal of Applied Gerontology*, 15, 397-413.

Gahan, C. & Hannibal, M. (1998). *Doing Qualitative Research Using QSR NUD·IST.* London: Sage Publications Ltd.

Gall, J., Fulmer, T., Paveza, G., & Reichel, W. (2000). *Handbook of Geriatric Assessment* (3rd edition). Gaithersburg, MD: Aspen Publications.

Gentile, K. (1991). A Review of the Literature on Interventions and Quality of Life in the Frail Elderly. In J. Birren, J. Lubben, J. Rowe & D. Deutchman (eds.), *The Concept and Measurement of Quality of Life in the Frail Elderly*. New York: Academic, 75-90.

Golant, S. (1999). *Report of the CASERA Project (Creating Affordable and Supportive Elder Renter Accommodations)*. Chicago, IL: Retirement Research Foundation.

Golant, S. (1998). Aging Boomer Communities will Cover Landscape. *Aging Today: The Bi-Monthly Newspaper of the American Society on Aging*, 19(1), 9-10.

Golant, S. (1992). *Housing America's Elderly: Many Possibilities/Few Choices.* Newbury Park, CA: Sage Publications.

Golant, S. (1991). Matching Congregate Housing Setting with a Diverse Elderly Population: Research and Theoretical Considerations. In L. Kay & A. Monk (eds.), *Congregate Housing for the Elderly: Theoretical, Policy, and Programmatic* Perspectives (2nd edition). New York: Haworth Press, 21-38.

Golant, S. (1990). The Metropolitization and Suburbanization of the U. S. Elderly Population: 1970-1988. *The Gerontologist*, 30, 80-85.

Golant, S. (1989). The Residential Moves, Housing Locations, and Travel Behavior of Older People: Inquires by Geographers. *Urban Geography*, 10 (1), 100-108.

Golant, S. (1986). The Suitability of Old People's Residential Environments: Insights from the Geographic Literature. *Urban Geography*, 7(5), 437-447.

Golant, S. (1984). The Geographic Literature on Aging and Old Age: An Introduction. *Urban Geography*, 5 (3), 262-272.

Golant, S. & LaGreca, A. (1994). Housing Qulaity of U. S. Elderly Households: Does Aging in Place Matter? *The Gerontologist*, 34, 804-814.

Golledge, R. & Stimson, R. (1997). *Spatial Behavior: A Geographic Perspective*. New York: The Guilford Press.

Gonzalez, T. (1997). An Empirical Study of Economies of Scope in Home Healthcare. *Health Services Research*, 32(3), 313-324.

Gould, J. & Ferguson, C. (1980). *Microeconomic Theory* (5th edition). Homewood, IL: Richard Irwin, Inc.

Griffith, J., Green, A., & Stewart, L. (1996). *Supportive Services, Social Integration, and Quality of Life for Frail Elderly Community Residents: A Comparative Analysis*. Research Triangle Institute, Research Triangle Park, NC. Paper presented at the 49th Annual Scientific Meeting of the Gerontological Society of America.

Gubrium, J. (1993). *Speaking of Life: Horizons of Meaning for Nursing Home Residents*. New York, NY: Aldine De Gruyter.

Gubrium, J. & Holstein, J. (1997). *The New Language of Qualitative Method*. New York: NY: Oxford University Press.

Gubrium, J. & Sankar, A., eds. (1994). *Qualitative Methods in Aging Research*. Thousand Oaks, CA: Sage Publications.

Harel, Z. & Harel, B. (1978). On-site Coordinated Services in Age-Segregated and Age-Integrated Public Housing. *The Gerontologist*, 18, 153-158.

Harrington, J. & Warf, B. (1995). *Industrial Location: Principles, Practice & Policy*. London: Routledge.

Hay, J. & Mandes, G. (1984). Home Health Care Cost-function Analysis. *Health Care Financing Review*, 5, 111-116.

Heidenheimer, A., Heclo, H., & Adams, C. (1983). *Comparative Public Policy: the Politics of Social Justice in Europe and America* (2nd edition). New York, NY: St. Martin's Press.

Heritage, J. (1984). *Garfinkel and Ethnomethodology*. Cambridge, MA: Polity Press.

Heumann, L. (1996). Assisted Living in Public Housing: A Case Study of Mixing Frail elderly and Younger Persons with Chronic Mental Illness and Substance Abuse Histories. *Housing Policy Debate*, 7 (3), 447-471.

Heumann, L. (1988). Assisting the Frail Elderly Living in Subsidized Housing for the Independent Elderly: A Profile of the Management and Its Support Priorities. *The Gerontologist*, 28, 625-631.

Heumann, L. (1985). Rent Subsidies and the Elderly. *Journal of Housing for the Elderly*, 2, 71-87.

Heumann, L. F. & Boldy, D. P., eds. (1993). *Aging in Place with Dignity: International Solutions relating to the Low-Income and Frail Elderly*. Westport, CT: Praeger Publishers.

Hitomi, K. (1989). Non-mass, Multi-product, Small-sized Production: The State of the Art. *Technovation*, 9, 357-369.

Holland, J., Ganz, L., Higgins, P., & Antonelli, K. (1995). Service Coordinators in Senior Housing. *Journal of Case Management*, 4, 108-111.

Holshouser, W., & Waltman, F. (1988). *Aging in Place: the Demographics and Service Needs of the Elderly in urban Public Housing*. Boston, MA: Citizens Housing and Planning Association.

Housing Assistance Council. (1997). *Rural Housing and Welfare Reform: HAC's 1997 Report on the State of the Nation's Rural Housing*. Washington, DC: Housing Assistance Council.

Hunt, M. & Ross, L. (1990). Naturally Occurring Retirement Communities: A Multiattribute Examination of Disability Factors. *The Gerontologist*, 30, 667-734.

Hurd, M. (1990). Research on the Elderly: Status, Retirement, and Consumption and Saving. *Journal of Economic Literature*, 28, 565-637.

Jacobs, B. (1986). The National Potential of Home Equity Conversion. *The Gerontologist*, 26, 496-504.

Kass, D. (1998). Economies of Scope and Home Healthcare. *Health Services Research*, 33 (4), 947-951.

Kass, D. (1987). Economies of Scale and Scope in the Provision of Home Health Services. *Journal of Health Economics*, 6 (June), 129-146.

Kaufman, S. (1994). The Social Construction of Frailty: An Anthropological Perspective. *Journal of Aging Studies*, 8, 45-58.

Kaufman, S. (1986). *The Ageless Self: Sources of Meaning in Late Life*. Madison, WI: The University of Wisconsin Press.

Kaye, L. Diamond, B, & Monk, A. (1986). *Congregate Housing for the Elderly: An Analysis of Program Adequacy and Effectiveness*. Paper presented at the 39th Annual Scientific Meeting of the Gerontological Society of America. Chicago, IL. Funded by the American Association of Retired Persons' Andrus Foundation.

Keen, C. (1997). *UF Researcher: Elderly Who Live in Low Income Housing Largely Ignored*. Press Release. Gainesville, FL: University of Florida.

Keith, R. (1998). Outsourcing: In Search of Service. *Retirement Community Business*, Summer, 14-15.

Khadduri, J., & Nelson, K. (1992). Targeting Housing Assistance. *Journal of Policy Analysis and Management*, 11 (1), 21-41.

Kingsley, G & Struyk, R. (1991a). II. Housing Policy Perspectives. Housing Policy in the United States: Trends, Future Needs, and Implications for Congregate Housing. In L. Kaye and A. Monk (eds.), *Congregate Housing for the Elderly: Theoretical, Policy, and Programmatic Perspectives*. New York: Haworth Press, 39-57.

Knight, B. & Walker, D. (1985). Toward a Definition of Alternatives to Institutionalization of the Frail Elderly. *The Gerontologist*, 25, 358-363.

Kontos, P. (1998). Resisting Institutionalization: Constructing Old Age and Negotiating Home. *Journal of Aging Studies*, 12(2), 167-185.

KRA Corporation. (1996). *Evaluation of the Service Coordinator Program*, Volume I: Study Findings. Prepared for the U. S. Department of Housing and Urban Development, Office of Policy Development and Research. Springfield, MD.

KRA Corporation. (1996). *Evaluation of the Service Coordinator Program*, Volume II: Case Studies. Prepared for the U. S. Department of Housing and Urban Development, Office of Policy Development and Research. Springfield, MD.

Kurowski, T., Schlenker, R. & Tricarico, G. (1979). *Applied Research in Home Health Services, Volumme II (Cost per Episode)*. Boulder, CO: University of Colorado Medical Center.

Lane, V. (1995). Best Management Practices in U. S. Public Housing. *Housing Policy Debate*, 6, 867-904.

Lanspery, S. (1997a). *Dying Buildings Come to Life: Coordinating Services in Senior Housing with Flexibility and Creativity.* Washington, D.C.

Lanspery, S. (1997b). *How to Guide: Service Coordination*. Prepared for the Department of Housing and Urban Development. Washington, D.C.

Larkin, P. (1974). *High Windows*. New York, NY: Farrar, Strauss, and Giroux.

Lawton, M. (1991). A Multidimensional View of Quality of Life in Frail Seniors. In J. Birren, J. Lubben, J. Rowe & D. Deutchman (eds.), *The Concept and Measurement of Quality of Life in the Frail Elderly*. New York: Academic, 4-27.

Lawton, M. (1989). Environmental Proactivity and Affect in Older People. In S. Spacapan & S. Oskamp (eds.), *The Social Psychology of Aging*. Newbury Park, CA: Sage, 235-263.

Lawton, M. (1985a). The Elderly in Context: Perspectives from Environmental Psychology and Gerontology. *Environment and Behavior*, 17, 501-519.

Lawton, M. (1985b). Housing and Living Environments of Older People. In R. Binstock & E. Shana (eds.), *Handbook of Aging and the Social Sciences* (2nd ed.). New York: Van Nostrand Reinhold.

Lawton, M. (1980). *Environment and Aging*. Monterey, CA: Brooks-Cole.

Lawton, M. (1976). The Relative Impact of Congregate and Traditional Housing on Elderly Tenants. *The Gerontologist*, 16, 237-242.

Lawton, M., Altman, I, & Wohlwill, J. (1984). Dimensions of Environmental Behavior Research. In I. Altman, M. Lawton, & J. Wohlwill (eds.), *Elderly People and the Environment*. New York: Plenum Press.

Lawton, M., Moss, M., & Grimes, M. (1985). The Changing Service Needs of Older Tenants in Planned Housing. *The Gerontologist*, 25, 258-264.

Lawton M & Nahemow, L. (1973). Ecology and the Aging Process. In C. Eisdorfer & M. Lawton (eds.), *The Psychology of Adult Development and Aging*. American Psychological Association, Washington, D.C., pp. 619-674.

Lemke, S. & Moos, R. (1989). Personal and Environmental Determinants of Activity Involvement Among Elderly Residents in Congregate Facilities. *Journal of Gerontology: Social Sciences*, S139-148.

Liebig, P. (1996). Area Agencies on Aging and the National Affordable Housing Act: Opportunities or Challenges. *Journal of Applied Gerontology*, 471-485.

Lipsman, R. (1996). Services and Supports to the Homebound Elderly with Mental Health Needs. *Journal of Long-term Home Health Care*, 15, 24-38.

Lipson, D., Norton, S., & Dubay, L. (1997). *Health Policy for Low-Income People in Florida*. State Report in the Assessing the New Federalism Series. Washington, DC: Urban Institute.

MacAdam, M, Capitman, Y., Yee, D. (1989). Case Management for Frail Elders: the Robert Wood Johnson Foundation's Program for Hospital Initiatives in Long-term Care. *Gerontologist*, 29, 734-744.

Malecki, E. (1991). *Technology and Economic Development: The Dynamics of Local, Regional, and National Change*. London: Longman Scientific & Technical.

Malmgren, J., Martin, M. & Nicola, R. (1996). Health Care Access of Poverty-level Older Adults in Subsidized Public Housing. *Public Health Reports*, 111, 260-263.

McAndrew, F. (1993). *Environmental Psychology*. Pacific Grove, CA: Brooks / Cole Publishing Company.

Merrill, J. & Hunt, M. (1990). Aging in Place: A Dilemma for Retirement Housing Administrators. *The Journal of Applied Gerontology*, 9 (1), 60-76.

Miles, M. & Huberman, A. (1994). *An Expanded Sourcebook: Qualitative Data Analysis*. Thousand Oaks, CA: Sage Publications.

Minkler, M. & Estes, C. (1991). *Critical Perspectives on Aging: The Political and Moral Economy of Growing Old*. Amityville, NY: Baywood Publishing Company, Inc.

Mitteness, L., Barker, J., & Finlayson, E. (1995). Residential Managers' Experience with Urinary Incontinence in Elderly Tenants. *The Journal of Applied Gerontology*, 14, 408-425.

Moore, S. (1991). Integrated Housing and Long-Term Care Services for the Elderly. A Social Marketing Approach. *Health Marketing Quarterly*, 9, 129-137.

Morris, C., & Dexter, E. (1989). Taking the Clinic to the Clients: Geriatric Health Care in a Residential Setting. *The Gerontological Society of America*, 29, 822-825.

Morrison, P. (1992). *Is "Aging in Place" a Blueprint for the Future?* Santa Monica, CA: Rand.

Nachison, J. (1994). The Housing Programs of the Department of Housing and Urban Development: Description and Issues. In W. E. Folts & D. E. Yeatts (eds.). *Housing and the Aging Population*. New York, NY: Garland, 83-104.

Nachison, J. (1985). Congregate Housing for the Low and Moderate Income Elderly -- A Needed Federal-State Partnership. *Journal of Housing for the Elderly*, 3, 65-80.

Nenno, M. (1994). Public Housing: A Pioneer in Housing Low-Income Older Adults. In W. Folts & D. Yeatts (eds.), *Housing and the Aging Population: Options for the New Century*. New York: Garland Publishing, Inc., 83-104.

Parmelee, P. & Lawton, M. (1990). The Design of Special Environments for the Aged. In J. Birren & K. Schaie (eds.), *Handbook of the Psychology of Aging* (2nd edition). San Diego, CA: Academic Press, pp. 464-488.

Pastalan, L. A., ed. (1990). *Aging in Place: The Role of Housing and Social Supports*. Binghamton, NY: Haworth Press.

Polivka, L., Dunlop, B., & Rothman, M. (1996). *Long-term Care for the Frail Elderly in Florida: Expanding Choices, Containing Costs* (Long-term Care Policy Series, Volume 1). Tampa, FL: Florida Policy Exchange Center on Aging.

Pollack, P. & DiGregorio, D. (1988). Aging-in-Place. *Journal of Extension*, 26 (4), 16-20.

Proeger, C. (2000). Housing and Services for Frail Seniors Interview. June 10.

Pynoos, J. (1995). Supportive Services? Fine. But How About Supportive Surroundings? *Perspectives in Aging*, 24, 20-23.

Pynoos, J. (1992). Linking Housing and Services. *Journal of Aging and Social Policy*, 3-4, 157-177.

Pynoos, J. & Golant, S. (1996). Housing and Living Arrangements for the Elderly. In R. Binstock & L. George (eds.), *Handbook of Aging and Social Sciences* (4th edition). New York, NY: Academic Press. 1-44

Pynoos, J. & Liebig, P. S., (eds.). (1995). *Housing Frail Elders: International Policies, Perspectives, and Prospects*. Baltimore, MD: The Johns Hopkins University Press.

Pynoos, J. & Parrott, T. (1996). The Politics of Mixing Older Persons and Younger Persons with Disabilities in Federally Assisted Housing. *The Gerontologist*, 36, 518-529.

Pynoos, J & Regnier, V. (1991). Improving Residential Environments for Frailty Elderly: bridging the Gap Between Theory and Practice. In J. Birren, J. Lubben, J. Rowe & D. Deutchman (eds.), *The Concept and Measurement of Quality of Life in the Frail Elderly*. New York: Academic, 91-119.

Pynoos, J., Hamburger, L., & June, A. (1990). Supportive Relationships in Shared Housing. In L. Pastalan (ed.), *Aging in Place: The Role of Housing and Social Supports*. New York: The Haworth Press, 1-24.

Rank, M. & Hirschl, T. (1999). Estimating the Proportion of Americans Ever Experiencing Poverty During Their Elderly Years. *Journal of Gerontology*, 54, S184-S193.

Raphael, D., Brown, I., & Renick, R. (1998). The Quality of Life of Seniors Living in the Community: A Conceptualization with Implications for Public Health Practice. *Canadian Journal of Public Health*, 33, 171-185.

Raphael, D., Cava, M., Brown, I, Renwick, R., Heathcote, K., Weir, N., Wright, K. & Kirwan, L. (1998). *Frailty: A Public Health Perspective*. Quality of Life Research Unit, Centre for Health Promotion. Toronto, Canada.

Redfoot, D. & Gaberlavage, G. (1991). Housing for Older Americans: Sustaining the Dream. *Generations*, 15 (3), 35-38.

Redfoot, D. & Sloan, K. (1991). Realities of Political Decision-making on Congregate Housing. In L. Kaye and A. Monk (eds.), *Congregate Housing for the Elderly: Theoretical, Policy, and Programmatic Perspectives*, 99-110. Binghamton, NY: Haworth Press.

Regnier, V., Hamilton, J., & Yatabe, S. (1991). *Best Practices in Assisted Living: Innovations in Design, Management, and Financing.* Los Angeles: Long Term Care National Resource Center at UCLA / USC.

Regnier, V. & Pynoos, J., eds. (1987). *Housing the Aged: Design Direction and Policy Considerations*. New York: Elsevier.

Research Triangle Institute. (1996). *Evaluation of the New Congregate Housing Services Program*, Second Interim Report. Prepared for U. S. Department of Housing and Urban Development, Office of Policy Development and Research. Research Triangle Park, NC.

Reynolds-Scanlon, S., Reynolds, S., Peek, M., Polivka, L, & Peek, C. (1999). *Profile of Older Floridians*. Tampa: Florida: Florida Policy Exchange Center on Aging.

Richter, D. (1996). *Expanding Services to Meet Community Needs in An Era of Change.* Washington, D. C.: American Association of Homes and Services for the Aging.

Roberts, H. (1991). Aging in Place. *Whole Earth Review*, 72, 116-119.

Rockwood, K. (1999). A Brief Instrument to Classify Frailty in Elderly People. *The Lancet*, 352, 205.

Rockwood, K. (1992). Screening for Frailty in Elderly Hospitalized Patients. *American Family Physician*. 39, 903.

Rockwood, K., Fox, R., Stolee, P, Robertson, D., & Beattie, B. (1994). Frailty in Elderly People: An Evolving Concept. *Canadian Medical Association Journal*, 150 (4): 489-495.

Rubinstein, R., Kilbride, J., & Nagy, S. (1992). *Elders Living Alone: Frailty and the Perception of Choice*. New York, NY: Aldine De Gruyter.

Ryther, B. (1987). *Aging in Place . . . Training for Managers*. Council of State Housing Agencies and the National Association of State Units on Aging: Washington, D.C.

Sayer, A. & Walker, R. (1992). *The New Social Economy: Reworking the Division of Labor*. Cambridge, MA: Blackwell Publishers.

Scheider, E., & Guralnik, J. (1990). The Aging of America: Impact on Health Costs. *Journal of the American Medical Association*, 253, 2335-2340.

Schulman, A. (1996). Service Coordination: Program Development and Initial Findings. *Journal of Long-Term Home Health Care*, 15 (Spring), 5-12.

Scott, A. (1988). *New Industrial Spaces*. London: Pion Limited.

Seifert, S. L. (1992). *Supportive Services for Low Income elderly in Public Housing*. Final Project Report to Administration on Aging, Department of Health and Human Services. Springfield, VA: National Technical Information Service.

Sheehan, N. (1996). Management Issues in Service Coordination: The Experience of the Resident Services Coordinator Program. *The Journal of Gerontological Social Work*, 26, 71-86.

Sheehan, N. (1993). *The Residential Services Coordinator Model: Service Coordination in Federally Assisted Senior Housing*. Paper Presented at the Annual Meeting of the Gerontological Society of America, New Orleans, LA.

Sheehan, N. (1992). *The Elderly Supportive Services Program: Bringing Service Coordination into Senior Housing*. A Joint Project by Connecticut Housing Finance Authority, Travelers Center on Aging, and the Connecticut Department n Aging.

Sheehan, N. (1986). Aging of Tenants: Termination Policy in Public Senior Housing. *The Gerontologist*, 25, 505-509.

Skinner, J. H. (1992). Aging in place: The Experience of African American and other minority elders. *Generations*, 16 (2) 49-51.

Staebler, R. (1991). Aging in Place: Providing Mental Health Services for the Elderly. *CARING Magazine*, May, 52-56.

Stanback, Jr., T., Bearse, P., Thierry, N., & Karasek, R. (1981). *Services: The New Economy*. Totowa, NJ: Allanheld, Osumun, & Co. Publishers.

Struyk, R. (1985). Future Housing Assistance Policy for the Elderly. *The Gerontologist*, 25, 41-46.

Struyk, R. & Katsura, H. (1987). Aging at Home: How the Elderly Adjust their Housing Without Moving. *Journal of Housing for the Elderly*, 4, 1-192.

Struyk, R., Page, D., Newman, S., Carroll, M., Ueno, M., Cohen, B., & Write, P. (1989). State Integrated Housing/Service Programs. In *Providing Supportive Services to the Frail Elderly in Federally Assisted Housing*. Washington, DC: Urban Institute Press, 35-64.

Tabron, J. (1995). Preiss-Stelle Place: Housing Older Adults. *Journal of Housing and Community Development*, 52, 23-25.

Teaff, J., Lawton, M., Nahemow, L., & Carlson, D. (1978). Impact of Age Integration on the Well-being of Elderly Tenants in Public Housing. *Journal of Gerontology*, 33, 126-133.

Thomas, D. (1995). *The Collected Poems of Dylan Thomas*. New York, NY: Simon and Schuster.

Thurow, L. (1996). The Birth of a Revolutionary Class. *New York Times Magazine*, May 19, 46-47.

Tierney, J. (1987). A Comparative Examination of the Residential Segregation of Persons 65 to 74 and persons 75 and Above in 18 United States Metropolitan Areas for 1970 and 1980. *Journal of Gerontology*, 42, 101-106.

U. S. Census Bureau. (2000). *United States Census Statistics and Demographic Information*. Washington, D.C.: Government Printing Office.

U. S. Congress. Congressional Budget Office. (1988). *Changes in the Living Arrangements of the Elderly, 1960-2030*. Washington, D.C.: U. S. Government Printing Office.

U. S. Congress. House. Committee on Ways and Means. (1991). *Green Book: Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means*. Report WMCP 102-9. Washington, D.C.: Government Printing Office.

U. S. Department of Housing and Urban Development. (2000). *Housing Our Elders: A Report Card on the condition and Needs of Older Americans*. Washington, D.C.: Office of Policy Development and Research.

U. S. Department of Housing and Urban Development. (1999). *Housing Our Elders: A Report Card on the condition and Needs of Older Americans*. Washington, D.C.: Office of Policy Development and Research.

U. S. Select Committee on Aging, House of Representatives. (1992). *Housing for Older Americans: Does HUD Have a Strategy?* Hearings before the Subcommittee on Housing and Consumer Interests of the Select Committee on Aging. Washington, D.C.: U. S. Government Printing Office.

U. S. Senate, Special Committee on Aging. (1994). *Developments in Aging: 1993*, Volume 1. Washington, D. C.: U. S. Government Printing Office.

Varady, D. (1984). Determinants of Interest in Senior Citizen Housing Among the Community Resident Elderly. *The Gerontologist*, 24, 392-395.

Varady, D, & Woodruff, F. (1987). *Factors Affecting Well-Being in Subsidized Rental Housing for the Independent Jewish Elderly: A Case Study of the Philada Project in Cincinnati*. A Report to the board of Directors of Philada.

Wacker, R., Roberto, K, & Piper, L. (1998). *Community Resources for Older Adults: Programs and Services in an Era of Change.* Thousand Oaks, CA: Sage Publications.

Warach, B. (1991). Enriched Housing for the Elderly: The JASA Experience (1968 – 1990). In L. Kaye & A. Monk (eds.), *Congregate Housing for the Elderly: Theoretical, Policy, and Programmatic Perspectives*. New York, NY: Haworth Press, 141-156.

Wasch, W. (1996). Transforming One's Own Home Can be Fulfilling -- Or Not! *Perspectives on Aging*, 24, 23-26.

Wehbring, K. (1995). *SAFE - Special Advocates for Elders, Program Evaluation.* Sextand Consultants, Inc. Portland, Oregon. Funded by Administration on Aging, Department of Health and Human Services, Washington, D.C.

Weiner, J. & Stevenson, D. (1998). Long-Term Care for the Elderly: Profiles of Thirteen States. Occasional Paper Number 12 in the *Assessing the New Federalism Series*. Washington, D.C.: Urban Institute.

Welfeld, I. (1988). *Where We Live: A Social History of American Housing*. New York, NY: Simon and Schuster.

Weissert, W. (1988). The National Channeling Demonstration: What We knew, Know Now and Still Need to Know. *Health Services Research*, 2, 175-187.

Werner, C., Altman, I. & Oxley, D. (1985). Temporal Aspects of Homes: A Transactional Perspective. In I Altman & C. Werner (eds.), *Home Environments: Volume 8 Human Behavior and Environment: Advances in Theory and Research.* New York: Plenum, 1-32.

Wetle, T. (1991). Resident Decision-Making and Quality of Life in the Frail Elderly. In J. Birren, J. Lubben, J. Rowe & D. Deutchman (eds.), *The Concept and Measurement of Quality of Life in the Frail Elderly*. New York: Academic, 279-296.

Wicker, A. (1982). *An Introduction to Ecological Psychology*. New York: Cambridge University Press. [

Williams, B. Action for Boston Community Development, Inc. (ABCD) Aging-in-Place Elderly Housing Project Interview. April 13.

Wilmoth, J. (2000). Unbalanced Social Exchanges and Living Arrangement Transitions Among Older Adults. *The Gerontologist*, 40, 64-74.

Wilson, M. (1998a). CASERA Project Interviews Database. University of Florida, Department of Geography.

Wilson, M. (1998b). Understanding Environmental Mis-Match in Orlando Village: A Case Study. University of Florida, Department of Geography.

Winograd, C., Gerety, M., Brown, E., & Kolodny, V. (1988). Targeting the Hospitalized Elderly for Geriatric Consultation. *Journal of American Geriatrics Society*, 36 (12), 1113-1119.

Winograd, C., Gerety, M., Chung, M., Goldstein, M., Dominguez, F, & Vallone, R. (1991). Screening for Frailty: Criteria and Predictors of Outcomes. *Journal of American Geriatrics Society*, 39 (8), 778-784.

Wise, D., ed. (1997). *Facing the Age Wave*. Stanford, CA: Hoover Institution Press.

Wolch, J. (1996). Community-Based Human Service Delivery. *Housing Policy Debate*, 7, 649-671.

Zeisel, John. (1975). *Sociology and Architectural Design*. Occasional Publication Reviewing New Fields for Social Science Development. New York, NY: Russell Sage Foundation.

Zola, I. (1972). Medicine as an Institution of Social Control. *Sociological Review*, 20, 487-504.

BIOGRAPHICAL SKETCH

Michael Phillips Wilson, a geographer and gerontologist, currently manages his own consulting and care management company, Michael P. Wilson and Associates, Inc. in Melbourne, Florida. He works with private, corporate, and local government clients dealing with issues of care management, senior housing, and long-term care.

Michael was born on April 17, 1969, to Robert Philips and Elizabeth Ann Wilson in Miami, Florida, but spent most of his formative years in Corpus Christi, Texas. In 1981, he and his family returned to Florida and settled in Melbourne. After graduating from Palm Bay High School in 1987, he attended the University of Florida and earned his Bachelor of Arts degree in English in 1991. In 1992, he married Jody Lynn Gorkiewicz, a clinical chemist at Shands Hospital. Shortly thereafter, he began graduate work at the University of Florida's Department of Geography with an emphasis in cultural geography, particularly literature and landscape. After graduating in 1996 with a Master of Arts degree in Geography, Michael was accepted into the doctoral program in the same department. He chose to work with Stephen M. Golant, examining issues of senior citizens and their housing needs. Michael worked with Dr. Golant on the CASERA (Creating Affordable Supportive Elder Renter Accommodations) Project to evaluate the situation of Florida's low-income elder renters.

Michael and Jody currently live in Melbourne, Florida with their dogs, Ruby and Jax, and two birds, Ginsbird and Paco.

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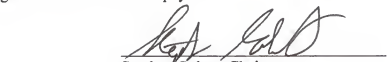

Stephen Golant, Chairman
Professor of Geography

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Edward Malecki
Professor of Geography

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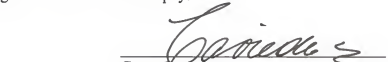

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